

# MARYLAND STATE DEPARTMENT OF HEALTH

13386 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

14650

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY IN 1b <b>4 y, 6 mo, 3 d.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>819 N. Castle St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Blanche</b> Middle <b>Allen</b> Last <b>Allen</b>		4. DATE OF DEATH Month <b>12</b> Day <b>28</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/19/83</b>
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months <b>12</b> Days <b>28</b> Hours <b>19</b> Min.	IF UNDER 24 HRS. Hours <b>19</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Unknown</b>	
14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Hospital Records</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypostatic Pneumonia</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture of hip</b>			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>4:50am</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>12/28</b> (County) <b>61</b> (State)
21. I certify that (I) (this hospital) attended the deceased from <b>12/28</b> to <b>12/28</b> , that (I) (we) last saw the deceased alive on <b>12/28</b> , and that death occurred at <b>4:50am</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Hildegard Heard Reissmann</b>		22b. DATE SIGNED <b>12/28/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Hilda Reissmann</b>		22d. ADDRESS <b>Crownsville State Hospital</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE THEREOF <b>1-9-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Agnes</b>	23d. LOCATION (City, town, or county) <b>Balto. Md.</b> (State)
24. FUNERAL DIRECTOR'S SIGNATURE <b>William Reese, Jr. - Anna. Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 11 '62</b>	
25b. REGISTRAR'S SIGNATURE			

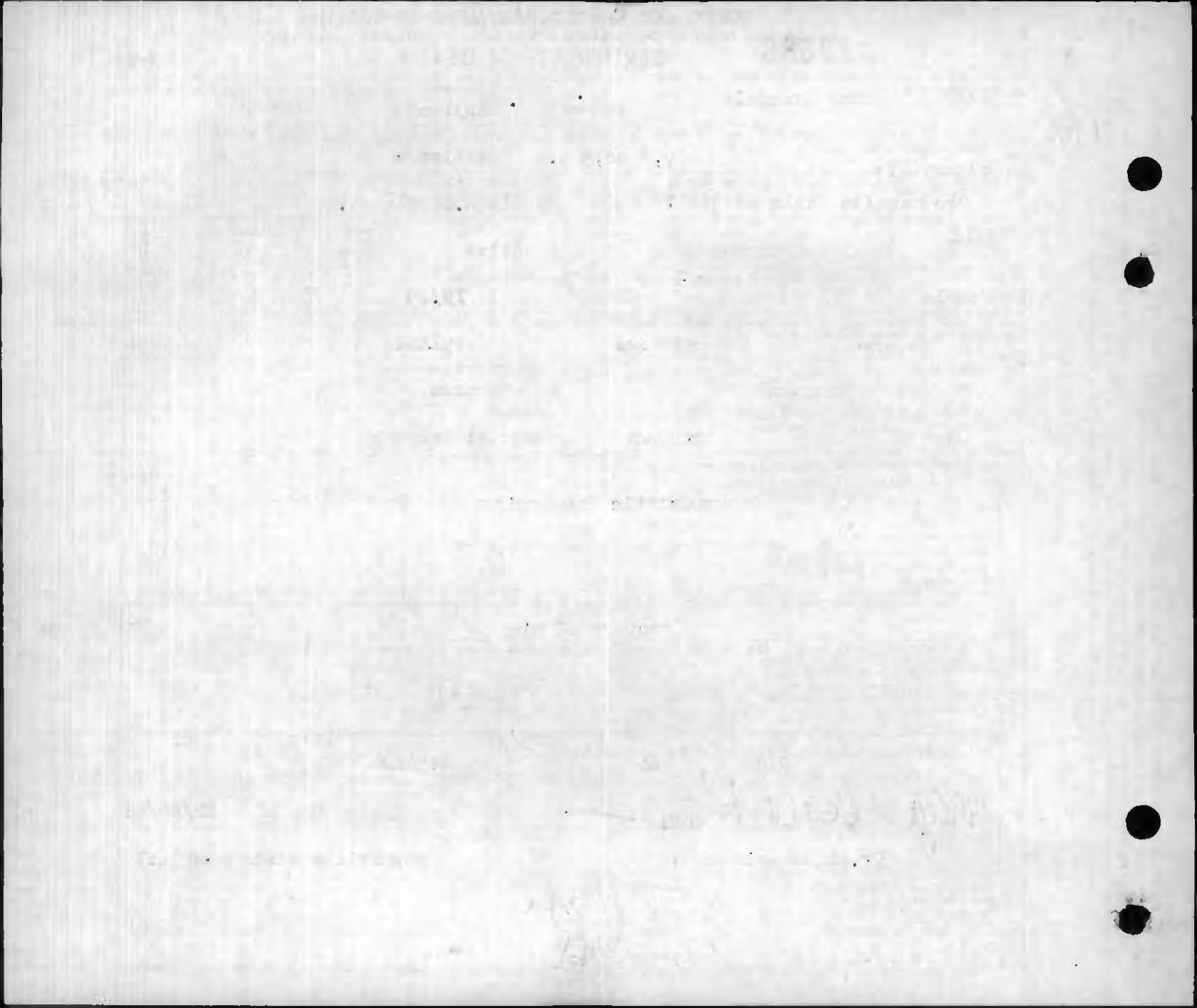
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HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

13387

13367

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY IN 1b <b>11 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Anne Arundel General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - Gambrills</b> d. STREET ADDRESS <b>Arundel View</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Leonard</b> First <b>AMES</b> Last		4. DATE OF DEATH Month <b>December</b> Day <b>22</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 1, 1885</b>
9. AGE (In years last birthday) <b>76 yrs.</b>		10. IF UNDER 1 YEAR Months <b>76</b>	11. IF UNDER 24 HRS. Hours <b>76</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer (ret.)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Nisners Bros. Store</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>CHARLES H. AMES</b>		14. MOTHER'S MAIDEN NAME <b>ESTELLE DUNLON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes WW 1</b>		16. SOCIAL SECURITY NO. <b>578 12 3498</b>	
17. INFORMANT <b>Mrs. Louise O. Ames</b>		Address <b>Same As #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>11 DAYS</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) ( <del>was not</del> ) attended the deceased from <b>Dec. 11, 1961</b> to <b>Dec. 22, 1961</b> , that (I) ( <del>was not</del> ) last saw the deceased alive on <b>Dec. 22, 1961</b> , and that death occurred at <b>8:55 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Edward S. Beck</b> 22c. PHYSICIAN'S NAME (Type) <b>Edward S. Beck, M.D.</b>		22b. DATE SIGNED <b>12/22/61</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>71 Franklin St., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>27th Dec. 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l. Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Fort Meyer, Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>A. P. Gough</b> ADDRESS <b>Glen Burnie, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 28 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 26

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13380 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13369

FOR STATE  
HEALTH DEPT.

**DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay must be explained. Please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>										2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Meade</b>										c. LENGTH OF STAY IN 1b <b>Odenton</b>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Fort Meade Hospital</b>										d. STREET ADDRESS <b>Box #335, 4th Avenue</b>									
3. NAME OF DECEASED (Type or print) First <b>KAREN</b> Middle <b>LYNN</b> Last <b>ASBURY</b>										4. DATE OF DEATH Month <b>December</b> Day <b>27</b> Year <b>19 61</b>									
5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										8. DATE OF BIRTH <b>9 Oct. 1960</b>									
9. AGE (In years last birthday) <b>1</b> yrs. <b>2</b> Months <b>2</b> Days <b>2</b> Hours <b>2</b> Min.										9. AGE (In years last birthday) <b>1</b> yrs. <b>2</b> Months <b>2</b> Days <b>2</b> Hours <b>2</b> Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)										10b. KIND OF BUSINESS OR INDUSTRY									
11. BIRTHPLACE (State or foreign country) <b>Laurel Maryland</b>										12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>									
13. FATHER'S NAME <b>Walter W. Asbury</b>										14. MOTHER'S MAIDEN NAME <b>Norman Lee Dragoo</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give year or dates of service)										16. SOCIAL SECURITY NO. <b>—</b>									
17. INFORMANT <b>Walter W. Asbury - 4th Ave. Odenton Md.</b>										17. INFORMANT Address									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pneumonia.</b> <b>493X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.										20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Charles S. Petty</b> M.D.										ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>									
EXAMINER'S NAME (Type) <b>Charles S. Petty, M.D.</b>										DEPUTY MEDICAL EXAMINER <input type="checkbox"/>									
Address (Street, city, town, or county)										DATE SIGNED <b>12/28/61</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>										22b. DATE THEREOF <b>12-30-61</b>									
22c. NAME OF CEMETERY OR CREMATORY <b>CHEN HAVEN</b>										22d. LOCATION (City, town, or country) (State) <b>CHEN BURIAL, Md.</b>									
23. FUNERAL DIRECTOR <b>H. P. NEWBERRY</b> ADDRESS <b>Plan Bunnies</b>										24a. REC'D BY REGISTRAR <b>DATE JAN 3 '62</b>									
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Evans</b>																			



50/12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

13390

13370

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN it d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u> d. STREET ADDRESS <u>118 Prince George St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Harvey</u> Middle <u>E.</u> Last <u>Avery</u>				<b>4. DATE OF DEATH</b> Month <u>December</u> Day <u>1</u> Year <u>1961</u>												
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Nov 15<sup>th</sup> 1897</u>		<b>9. AGE</b> (In years last birthday) <u>64</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>				
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Harbor master for Annapolis City</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Shady Side Md</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>U.S.A.</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>				
<b>13. FATHER'S NAME</b> <u>Walter S. Avery</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Ann Crandall</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>  </u> <b>16. SOCIAL SECURITY NO.</b> <u>  </u> <b>17. INFORMANT</b> <u>  </u> Address <u>  </u>								
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> 260X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary Artery Disease</u> (c), stating the underlying cause last. <u>Diabetes m</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <u>  </u>												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>20A</u> <u>5 yrs.</u> <u>5 yrs</u>				
<b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>												<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>		<b>20f. (City or town)</b> (County) (State) <u>  </u>		<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>1953</u> 19 <u>  </u> to <u>12-1-61</u> , that (I) (we) last saw the deceased alive on <u>12-15-61</u> 19 <u>  </u> , and that death occurred <u>am</u> P.M., from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>Frank M. Shipley</u>				<b>22b. PHYSICIAN'S NAME (Type)</b> <u>Frank M. Shipley M.D.</u>		<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22c. DATE SIGNED</b> <u>12-3-61</u>								
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>Dec 5<sup>th</sup> 1961</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Woodfield Cent</u>		<b>23d. LOCATION (City, town or county)</b> (State) <u>Galesville AGO Md</u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John M. Saylor Sons</u>			<b>25a. REC'D BY REGISTRAR</b> <u>DEC 6 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles S. Harris</u>	

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CONTRACT NO. 1300

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TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

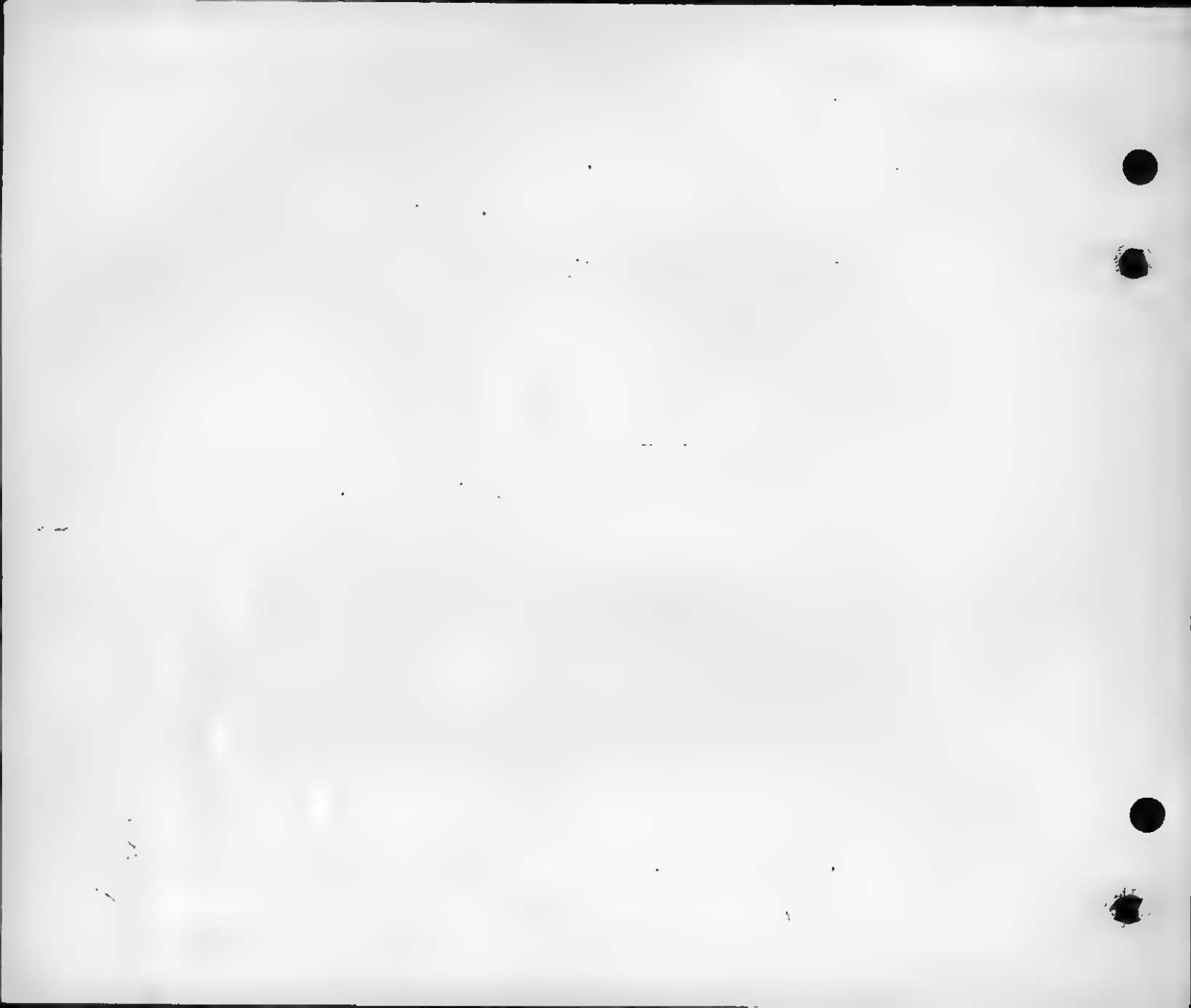
13391

Items 3, 13 & 14 Film G305 1/5/62

13371

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY IN 1b <b>2 Mo, 21 d.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Warshaw</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Warshaw</b> d. STREET ADDRESS <b>Rt. #3, Box 27</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Gurnie Ball</b> <sup>First</sup> <b>Alias</b> <sup>Middle</sup> <b>Geraldine Baker</b> <sup>Last</sup> <b>Baker, Geraldine alias Ball, Gurnie</b>		4. DATE OF DEATH Month <b>12</b> Day <b>27</b> Year <b>1961</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1943</b>
9. AGE (In years last birthday) <b>18</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>18</b> Days <b>27</b> Hours <b>18</b> Min. <b>18</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	
11 BIRTHPLACE (State or foreign country) <b>Virginia</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Ball</b>		14. MOTHER'S MAIDEN NAME <b>Lottie BALL Lane</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>223-18-7778</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>Malignant brain tumor /Oligodendroglioma/</b> IMMEDIATE CAUSE (a) <b>193.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>193.0</b> DUE TO (c) <b>193.0</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>193.0</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10/6</b> to <b>12/27</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>12/27</b> , 19 <b>61</b> , and that death occurred at <b>4:25 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Hilda Reissmenn</b>		22b. DATE SIGNED <b>12/27/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Hilda Reissmenn</b>		22d. ADDRESS <b>Crownsville State Hospital</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>12-31-61</b>		23b. DATE THEREOF <b>12-31-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mulberry Baptist Church</b>		23d. LOCATION (City, town, or county) (State) <b>Emmertown Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Eugene W. L. ...</b>		25a. REC'D BY REGISTRAR <b>DATE JAN 2 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>William E. Thomas</b>			

MEDICAL CERTIFICATION



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13392

CERTIFICATE OF DEATH  
Item 7, See City and State Certificate # D- 72013372

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel County</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY IN 1b <b>24 years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Crownsville State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b> d. STREET ADDRESS <b>1523 E. Chase St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Margery (MARJORIE) (none)</b>		4. DATE OF DEATH Last <b>Bass</b> Month <b>12</b> Day <b>2</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 22, 1928</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		9. AGE (in years last birthday) <b>33</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Matson T. Bass</b>	
14. MOTHER'S MAIDEN NAME <b>Inez Bass</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Matson T. Bass</b> Address <b>1523 E. Chase St., Balto., Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute cardiac failure</b> Conditions, if any, which gave rise to immediate cause (b) <b>old pulmonary tuberculosis.</b> (a), stating the underlying cause last. (c) <b>Hypertension - Mental depression - Epilepsy</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONSIDERED ON GIVEN IN PART I (a) " (b) " (c) " INTERVAL BETWEEN ONSET AND DEATH <b>Sudden.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>was found dead in bed.</b>			
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from... <b>1... 7... 1959</b> to <b>12... 2... 1961</b> , that (I) (we) last saw the deceased alive on <b>12... 2... 1961</b> , and that death occurred at <b>5:05 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>L. Benedict M.D.</b>		22b. DATE SIGNED <b>DEC 8 '61</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. BENEDICT M.D.</b>		22d. ADDRESS <b>CROWN SVILLE STATE HOSPITAL</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL 12/6/61</b>		23b. DATE THEREOF <b>12/6/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Park</b>		23d. LOCATION (City, town or county) (State) <b>Arbutus Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Malcolm E. Dickman</b>		25a. REC'D BY REGISTRAR <b>DEC 8 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Malcolm E. Dickman</b>		25c. ADDRESS <b>1129 N. Caroline St.</b>	

11-11-11



11-11-11

11-11-11

TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

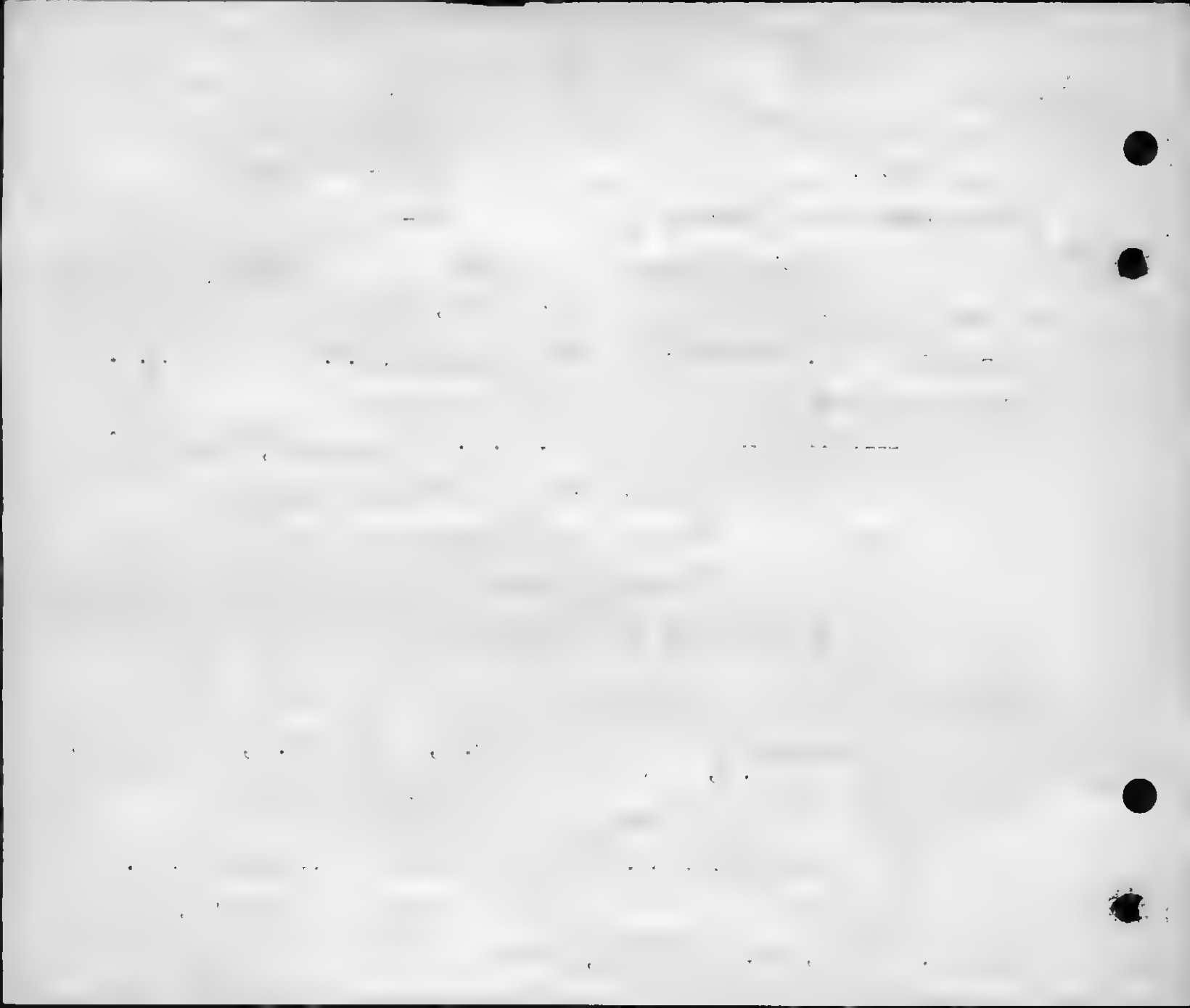
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13393

## CERTIFICATE OF DEATH

13373

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - Edgewater</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>Box-342</b>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Lottie Elizabeth BEARD</b>		<b>4. DATE OF DEATH</b> Month <b>December</b> Day <b>3</b> Year <b>1961</b>	
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>January 12, 1879</b>
<b>10a. USUA. OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Clerk-Retired</b>		<b>11. BIRTHPLACE</b> (County & State, or land in country) <b>Washington, D.C.</b>	
<b>13. FATHER'S NAME</b> <b>Christopher Murphy</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Catherine Jones</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>	
<b>17. INFORMANT</b> <b>Mr. Wm. W. Beard</b>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Heart Failure</b> DUE TO <b>Myocardial Infarction</b> Conditions, if any, which gave rise to immediate cause (b) <b>Coronary Artery Disease</b> (c) <b>Causes unknown</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>9 listed for similar condition June 1961</b>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) <del>did not</del> attended the deceased from Dec. 1, 1961, to Dec. 3, 1961, that (I) <del>was</del> last saw the deceased alive on Dec. 3, 1961, and that death occurred at M. from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <b>Maurice Klawans</b>		<b>22b. DATE SIGNED</b> <b>Dec. 3, 1961</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Maurice Klawans, M.D.</b>		<b>22d. ADDRESS</b> <b>31 Southgate Ave., Annapolis, Md.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>		<b>23b. DATE THEREOF</b> <b>12/7/61</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>GEORGE WASHINGTON CEMETERY</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>PRINCE GEORGE'S, MARYLAND</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Raymond E. Pimprey</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DEC 6 '61</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur P. Pimprey</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

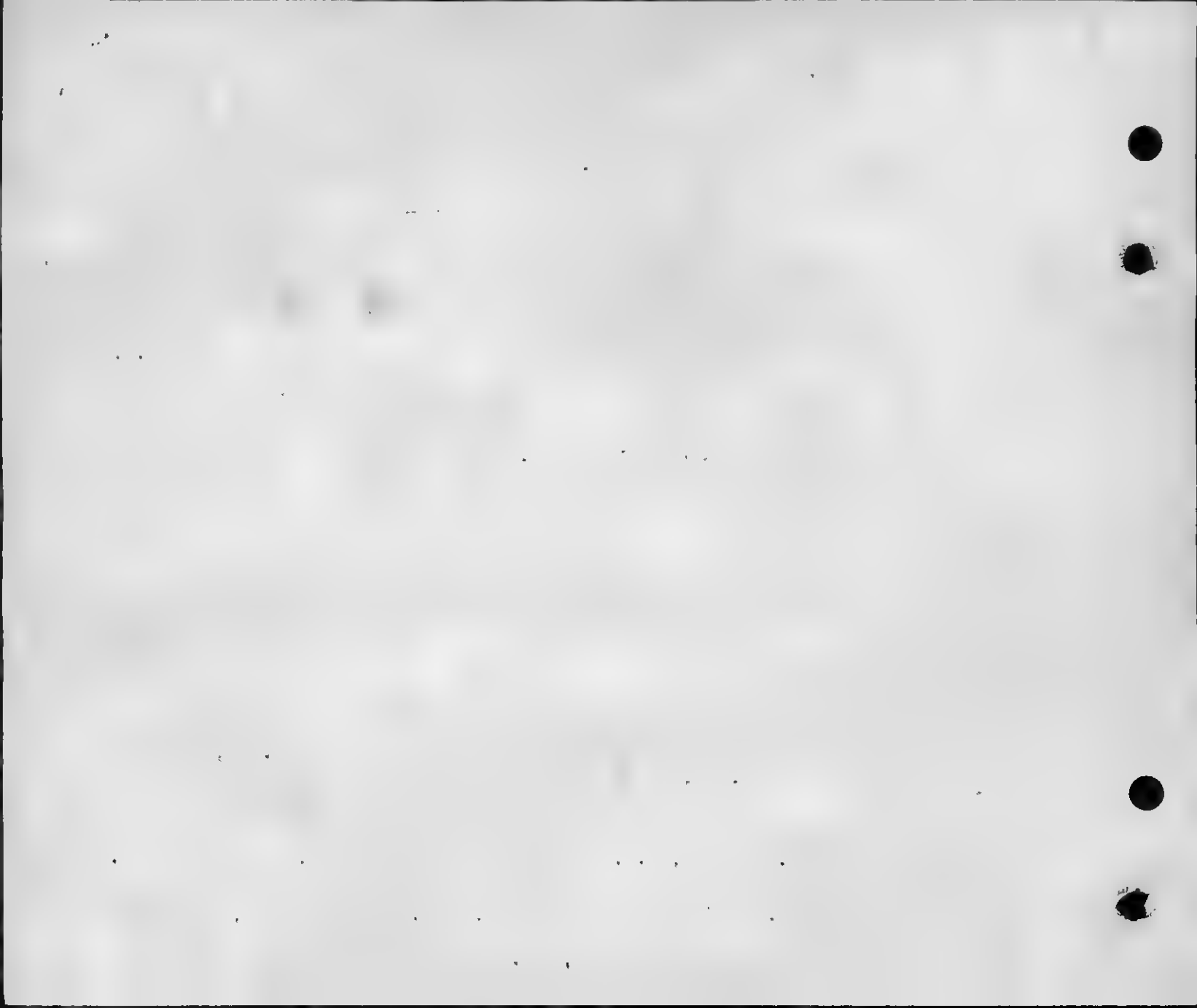
## CERTIFICATE OF DEATH

13394

13374

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY IN lb <b>15 min.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institutions: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - Odenton</b> d. STREET ADDRESS <b>Box-184 A</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>BEHRINGER</b> Last <b>BEHRINGER</b>		4. DATE OF DEATH Month <b>December</b> Day <b>21</b> Year <b>19 61.</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 25, 1888</b>
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months <b>72</b> Days <b>72</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Alabama</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Daniel Brown</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Quinley</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Mr. Harold Behringer - Same As #2</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (e) <b>Diabetic Coma</b> <b>260X</b> DUE TO <b>Diabetic</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Diabetic</b> (c) <b>Diabetic</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART I (e) <b>Diabetic</b>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (signature) attended the deceased from <b>Dec. 21, 1961</b> , that (I) (signature) saw the deceased alive on <b>Dec. 21, 1961</b> , and that death occurred at <b>2:55 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Frank M. Shipley, M.D.</b>		22b. DATE SIGNED <b>12/21/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Frank M. Shipley, M.D.</b>		22d. ADDRESS <b>121 Cathedral St., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>26 Dec. '1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l. Cem.</b>	23d. LOCATION (City, town or county) (State) <b>Fort Meyer, Virginia</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Glen Burnie, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 28 '61</b>	25b. REGISTRAR'S SIGNATURE <b>C. L. S. Evans</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, and 3 retained by the hospital or attending physician. Page 4 must be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

<div> <div>1</div> <div> <div>13</div> <div>I</div> </div> </div> <div> <div> <div>13395</div> <div>Item 9 Film G303</div> </div> <div> <div>12/27/61</div> <div>mb</div> </div> <div> <div>13375</div> <div></div> </div> </div> <div> <div> <div>1. PLACE OF DEATH</div> <div>a. COUNTY</div> <div>Anne Arundel</div> <div>MARYLAND</div> <div>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)</div> <div>Annapolis</div> <div>c. LENGTH OF STAY IN 1b</div> <div>22 days</div> <div>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)</div> <div>Anne Arundel General Hospital</div> </div> <div> <div>2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)</div> <div>a. STATE</div> <div>Maryland</div> <div>b. COUNTY</div> <div>Anne Arundel</div> <div>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)</div> <div>X RURAL - Gambrills</div> <div>d. STREET ADDRESS</div> <div>Box-340</div> <div>e. IS RESIDENCE ON A FARM?</div> <div>YES <input type="checkbox"/> NO <input type="checkbox"/></div> </div> </div> <div> <div>3. NAME OF DECEASED (Type or print)</div> <div>First</div> <div>Jame</div> <div>Middle</div> <div>Betheau</div> <div>Last</div> <div></div> <div>4. DATE OF DEATH</div> <div>Month</div> <div>December</div> <div>Day</div> <div>17</div> <div>Year</div> <div>1961</div> </div>											
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5. SEX

Male

6. COLOR OR RACE

Negro

7. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

12-25-1901

9. AGE (In years last birthday)

60 yrs

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10b. KIND OF BUSINESS OR INDUSTRY

Construction

11. BIRTHPLACE (County & State or foreign country)

South Carolina

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Shilbert

14. MOTHER'S MAIDEN NAME

Lilly Lane

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)

no

16. SOCIAL SECURITY NO.

577-24-746

17. INFORMANT

Maggie Brown - Wash. D.C.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cerebral hemorrhage - hypertensive

3 weeks

445X

Conditions, if any which gave rise to immediate cause (a), stating the underlying cause test.

(b)

Acute cardiac failure

2 days

(c)

Chronic hypertension & renal arteriosclerosis

8 years

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY

Month, Day, Year

19

20d. INJURY OCCURRED

While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 11:00 P.M. to 12:16 A.M., 1961, that (I) (we) last saw the deceased alive on 12-10-1961, and that death occurred at 11:15 A.M. from the causes and on the date stated above.

22a. SIGNATURE

Bethand C R Jones

M.D.

ATTENDING PHYS.

22b. DATE SIGNED

12-17-61

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REBURYAL (Specify)

Burial

23b. DATE THEREOF

12-22-61

23c. NAME OF CEMETERY OR CREMATORY

Brewer Hill

23d. LOCATION (City, town or country)

Annapolis, Md.

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

William Reese, Jr.

ADDRESS

Annap. Md.

25a. REC'D BY REGISTRAR

DEC 21 '61

25b. REGISTRAR'S SIGNATURE

William S. Kenna



FOR STATE  
HEALTH DEPT.

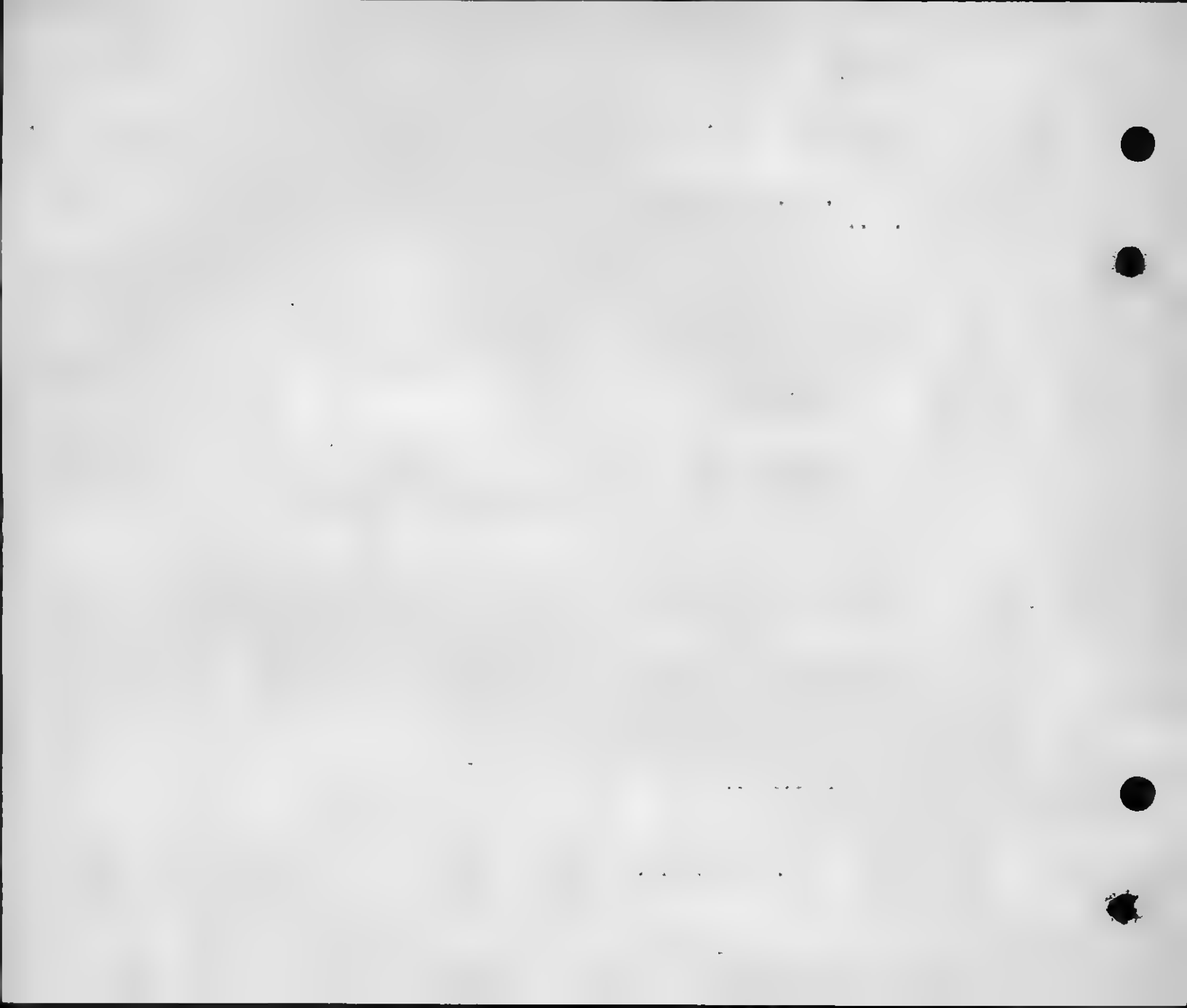
DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, use execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME  
5M 9/60

(M)

MEDICAL CERTIFICATION

<div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, use execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.</div> </div> </div> <div> <div> <div>VS. A15ME</div> <div>5M 9/60</div> </div> <div> <div>(M)</div> </div> </div> <div> <div> <div>123396</div> <div>13376</div> </div> <div> <div> <div>1. PLACE OF DEATH</div> <div>a. COUNTY</div> <div> <div>Anne Arundel County,</div> <div>MARYLAND</div> </div> </div> <div> <div> <div>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)</div> <div>c. LENGTH OF STAY IN TB</div> </div> <div> <div>Rural</div> <div></div> </div> </div> <div> <div> <div>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)</div> <div>The home of Mrs. Wm. Kirkpatrick,</div> <div>Harwood P. O., Anne Arundel County</div> </div> <div> <div> <div>e. IS RESIDENCE ON A FARM?</div> <div>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></div> </div> </div> </div> <div> <div> <div>2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)</div> <div>a. STATE</div> <div>b. COUNTY</div> <div> <div>Maryland</div> <div>Anne Arundel Co.</div> </div> </div> <div> <div> <div>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)</div> <div>d. STREET ADDRESS</div> </div> <div> <div>Harwood</div> <div></div> </div> </div> <div> <div> <div>3. NAME OF DECEASED (Type or print)</div> <div>THOMAS</div> </div> <div> <div> <div>4. DATE OF DEATH</div> <div>Month</div> <div>Day</div> <div>Year</div> </div> <div> <div>December 4,</div> <div>1961</div> </div> </div> <div> <div> <div>5. SEX</div> <div>Male</div> </div> <div> <div> <div>6. COLOR OR RACE</div> <div>Colored</div> </div> <div> <div> <div>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></div> <div>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></div> </div> </div> </div> <div> <div> <div>8. DATE OF BIRTH</div> <div>4-2-1904</div> </div> <div> <div> <div>9. AGE (In years last birthday)</div> <div>57 yrs.</div> </div> <div> <div> <div>IF UNDER 1 YEAR</div> <div>Months</div> <div>Days</div> <div>Hours</div> <div>M'n.</div> </div> </div> </div> <div> <div> <div>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div>Saborer</div> </div> <div> <div> <div>10b. KIND OF BUSINESS OR INDUSTRY</div> <div></div> </div> <div> <div> <div>11. BIRTHPLACE (State or foreign country)</div> <div>Maryland</div> </div> <div> <div> <div>12. CITIZEN OF WHAT COUNTRY?</div> <div>U.S.A.</div> </div> </div> </div> <div> <div> <div>13. FATHER'S NAME</div> <div>John Blake</div> </div> <div> <div> <div>14. MOTHER'S MAIDEN NAME</div> <div>Kate Harris</div> </div> </div> </div> <div> <div> <div>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, Unknown) (If yes give war or dates of service)</div> <div>No</div> </div> <div> <div> <div>16. SOCIAL SECURITY NO.</div> <div>315-16-1210</div> </div> <div> <div> <div>17. INFORMANT</div> <div>Virian Holland Edgewater Md.</div> </div> </div> </div> <div> <div> <div>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</div> <div> <div>PART I. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a)</div> <div>Arteriosclerotic Cardiovascular Disease</div> </div> <div> <div> <div>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</div> <div>DUE TO</div> <div>(b)</div> <div>DUE TO</div> <div>(c)</div> </div> </div> <div> <div> <div>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</div> <div>19. WAS AUTOPSY PERFORMED?</div> <div>Partial <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/></div> </div> </div> </div> <div> <div> <div>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/></div> <div>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</div> </div> <div> <div> <div>20c. TIME OF INJURY</div> <div>Month, Day, Year</div> <div>Hour a.m.</div> <div>p.m.</div> <div>19</div> </div> <div> <div> <div>20d. INJURY OCCURRED</div> <div>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></div> </div> <div> <div> <div>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</div> <div>Partial</div> </div> <div> <div> <div>20f. (City or town)</div> <div>(County)</div> <div>(State)</div> </div> </div> </div> </div> <div> <div> <div>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></div> <div> <div>CHIEF MEDICAL EXAMINER <input type="checkbox"/></div> <div>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/></div> <div>DEPUTY MEDICAL EXAMINER <input type="checkbox"/></div> </div> </div> <div> <div> <div> <div>ACTUAL SIGNATURE</div> <div>EXAMINER'S NAME (Type)</div> </div> <div> <div> <div>HOWARD G. SHAUB, M.D.</div> <div>Address (Street, city, town, or county)</div> </div> <div> <div>DATE SIGNED</div> <div>12/5/61</div> </div> </div> </div> <div> <div> <div>22a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>22b. DATE THEREOF</div> <div>22c. NAME OF CEMETERY OR CREMATORY</div> <div>22d. LOCATION (City, town, or country)</div> <div>(State)</div> </div> <div> <div> <div>Burial</div> <div>12-8-1961</div> <div>Adams Chapel Bayard</div> <div>Md.</div> </div> </div> </div> <div> <div> <div>24a. REC'D BY REGISTRAR</div> <div>24b. REGISTRAR'S SIGNATURE</div> </div> <div> <div> <div>DATE</div> <div>DEC 7 '61</div> </div> <div> <div> <div>William Reese</div> <div>Anna Md.</div> </div> </div> </div> </div> </div></div></div></div></div></div></div></div></div></div></div></div></div></div>											
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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

13397

13377

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u> c. LENGTH OF STAY IN 1b <u>1</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Forest Drive - Lake Shore</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena / (Lake Shore)</u> d. STREET ADDRESS <u>Rt. 7 - Box #529 / Forest Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
<b>3. NAME OF DECEASED</b> (Type or print) <u>August F. Boblitz, Jr.</u>		<b>4. DATE OF DEATH</b> Month <u>December</u> Day <u>12</u> Year <u>1961</u>		<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Nov - 1896</u>		<b>9. AGE</b> (In years last birthday) <u>65</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Painter (ret.)</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Lanham Co.</u>		<b>11. BIRTHPLACE</b> (Country & State, or foreign country) <u>Baltimore, Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>William H. Boblitz</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary E. (Unknown)</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes W.W.I</u>				<b>16. SOCIAL SECURITY NO.</b> <u>220-09-5522</u>				<b>17. INFORMANT</b> Address <u>Mrs. Emma C. Boblitz - Same as #2</u>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>carcinoma of the right kidney</u> (b) <u>with extensive metastases</u> (c) <u>6 months</u> DUE TO <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> (b) <u>  </u> (c) <u>  </u>																					
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>																					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>				<b>20f. (City or town)</b> (County) (State) <u>  </u>									
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>March 16, 1961</u> <b>to</b> <u>December 2, 1961</u> <b>that (I) (we) last saw the deceased alive on</b> <u>December 1, 1961</u> <b>and that death occurred at</b> <u>9:30 a.m.</u> <b>from the causes and on the date stated above.</b>																					
<b>22a. SIGNATURE</b> <u>R. M. McLaughlin</u>								<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>				<b>22b. DATE SIGNED</b> <u>12/2/61</u>									
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>R. M. McLaughlin</u>								<b>22d. ADDRESS</b> <u>3708 Mountain Rd. Pasadena, Md.</u>													
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>6-1 Dec - 1961</u>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Glen Haven Mem. Pk.</u>				<b>23d. LOCATION (City, town or county)</b> (State) <u>Glen Burnie, Md.</u>									
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>R. V. Singleton</u>								<b>25a. REC'D BY REGISTRAR</b> DATE <u>DEC 7, '61</u>				<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Evans</u>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

13398

Items 13 & 14 Film G302 12/13/61 jwk

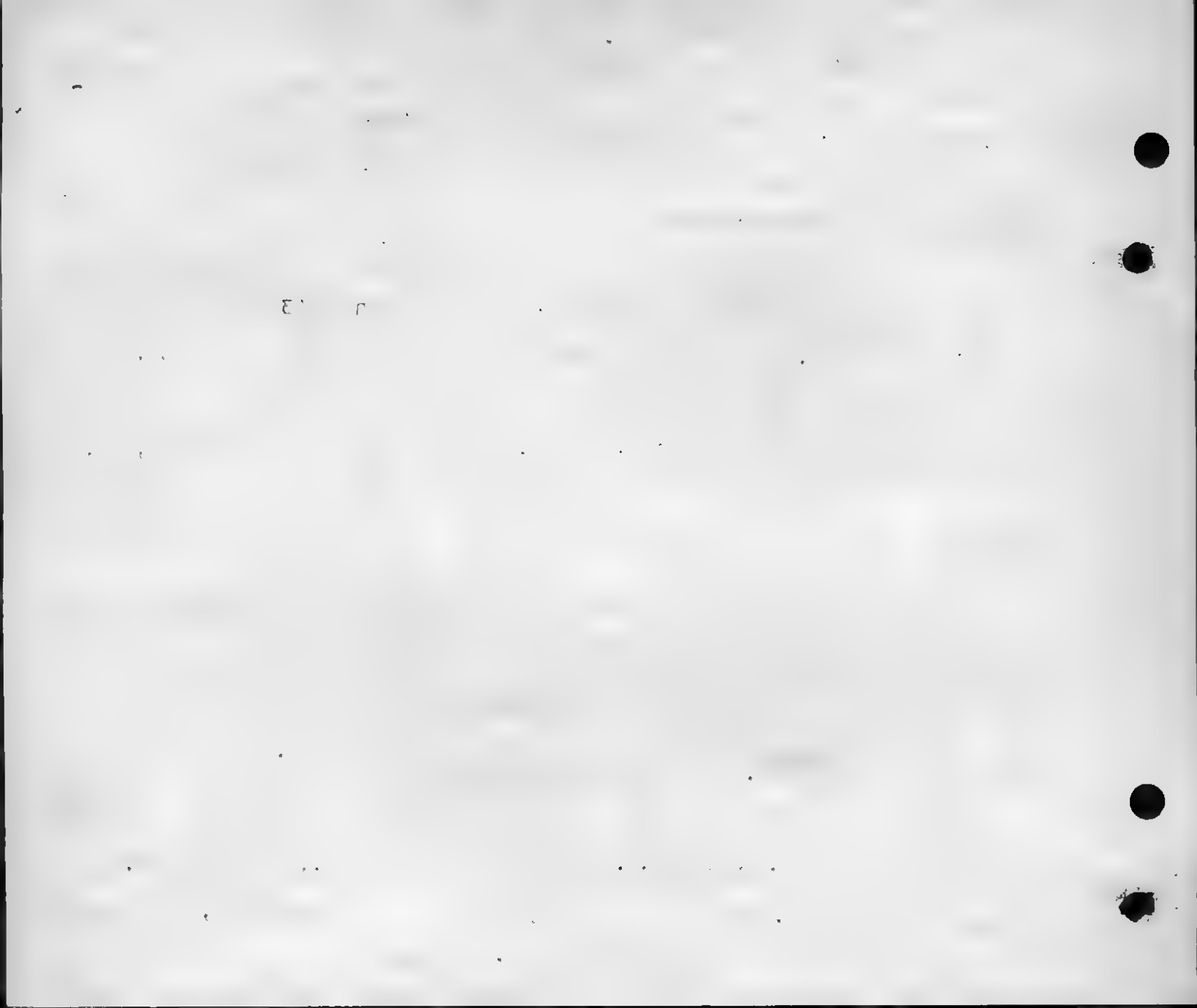
13378

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>			<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			c. LENGTH OF STAY IN lb <u>X</u> <u>RURAL - Gambrills</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>(Dead on arrival)</u> <u>Anne Arundel General Hospital</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) <u>Adam</u>			<b>4. DATE OF DEATH</b> <u>BOSCHERT</u> <u>December</u> <u>5</u> <u>1961</u>		
<b>5. SEX</b> <u>Male</u>			<b>6. COLOR OR RACE</b> <u>White</u>		
<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			<b>8. DATE OF BIRTH</b> <u>January 21, 1888</u> <u>73</u> <u>21</u> <u>73</u>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Blacksmith (ret.)</u>			<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u>		
<b>13. FATHER'S NAME</b> <u>Andrew Boschert</u>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>			<b>16. SOCIAL SECURITY NO</b> <u>unknown</u>		
<b>17. INFORMANT</b> <u>Mr. George Boschert</u>			<b>Address</b> <u>Gambrills, Md.</u>		
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Congestive Failure</u> DUE TO (b) <u>Chronic Congestive Failure</u> (c) <u>Chronic Congestive Failure</u>			<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>2 yr.</u> <u>4 yr.</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II(a)					
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)		
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>a.m.</u> <u>19</u>			<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			<b>20f. (City or town)</b> (County) (State)		
<b>21. I certify that (I) <u>Richard N. Peeler</u> attended the deceased from <u>May</u> <u>1958</u> to <u>Dec.</u> <u>1961</u>, that (I) <u>last</u> saw the deceased alive on <u>Dec.</u> <u>1961</u>, and that death occurred at <u>9:45 AM</u> from the causes and on the date stated above.</b>					
<b>22a. SIGNATURE</b> <u>Richard N. Peeler, M.D.</u>			<b>22b. DATE SIGNED</b> <u>12/5/61</u>		
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Richard N. Peeler, M.D.</u>			<b>22d. ADDRESS</b> <u>121 Cathedral St., Annapolis, Md.</u>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>			<b>23b. DATE THEREOF</b> <u>9th Dec. 1961</u>		
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Our Lady of the Field</u>			<b>23d. LOCATION</b> (City, town or county) (State) <u>Millersville, Maryland</u>		
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Thomas W. Singleton</u>			<b>25a. REC'D BY REGISTRAR</b> <u>Glen Burnie, Md.</u>		
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Kline</u>			<b>DATE</b> <u>DEC 11 '61</u>		

200 Grain Highway

TO HOSPITAL - ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 48 hours after death. The certificate must be retained by the hospital or attending physician. The medical director, after this certificate has been signed by the attending physician and completed, must be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

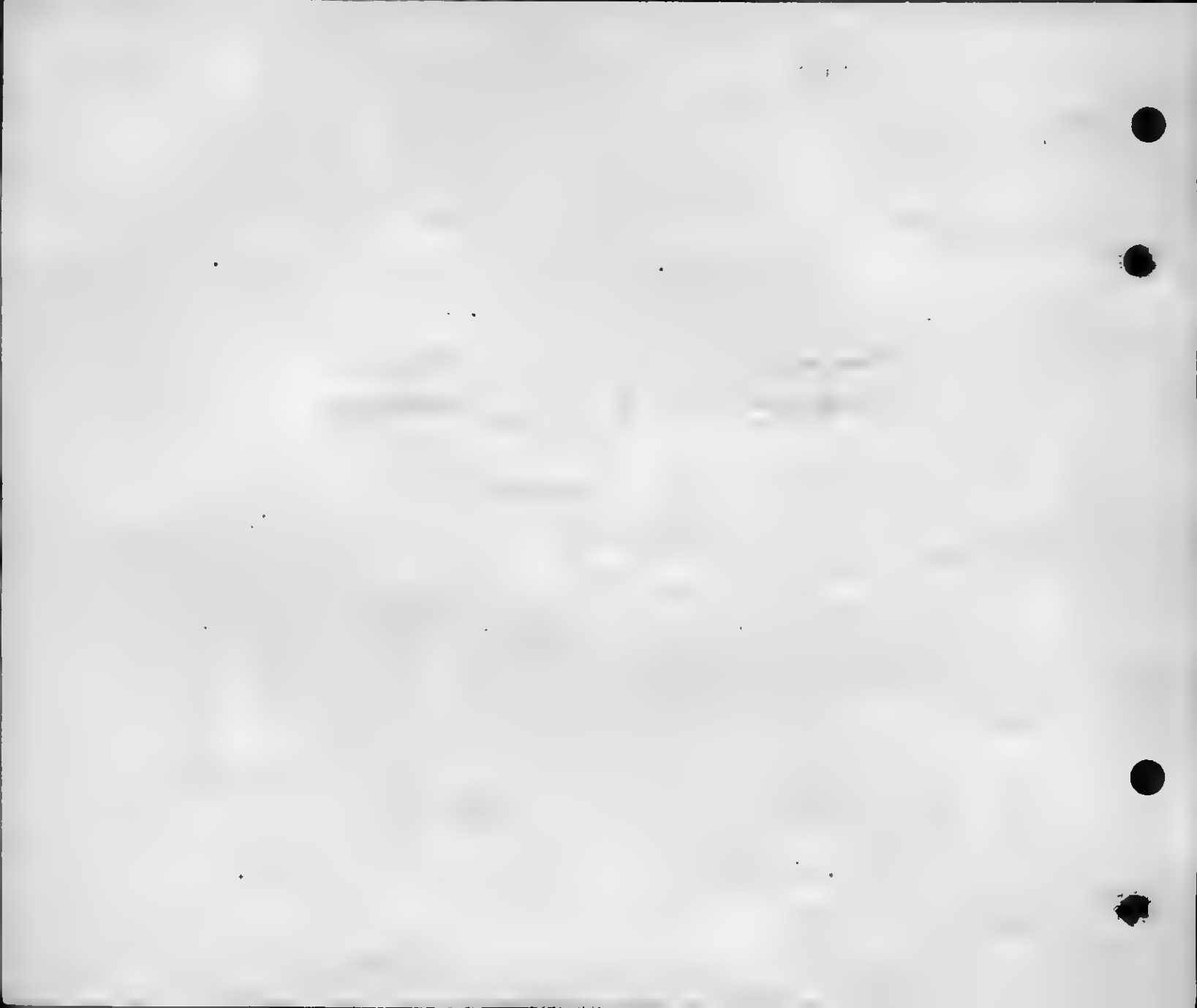
VR AIS (4)  
15M 7/61



TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13399					13379				
CERTIFICATE OF DEATH					Item 23b Film 0305 1/8/62 gh				
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Route 4 Annapolis</u>				
c. LENGTH OF STAY IN TB <u>10 days</u>					d. STREET ADDRESS <u>Arnold rd</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle <u>M.</u> Last <u>Brooks</u>					4. DATE OF DEATH Month <u>Dec.</u> Day <u>23</u> Year <u>19 61</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 15, 1889</u>		9. AGE (In years last birthday) <u>72</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?		IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME <u>Unknown</u>					14. MOTHER'S MAIDEN NAME <u>Unknown</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT Address		
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u>									
284X DUE TO <u>Acute Pancreatitis</u>									
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO <u>Cholelithiasis</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Uremia; Arteriosclerotic hypertensive carido-vascular renal disease</u>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Dr. Lionel Mapp</u>					22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type) <u>Dr. Lionel Mapp</u>					22d. ADDRESS <u>Crownsville State Hospital Crownsville, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>12-26-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cem</u>		23d. LOCATION (City, town or county) (State) <u>Anne Arundel</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Chay O Wilson</u>					25a. REC'D BY REGISTRAR <u>Arthur L. Thomas</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>		
ADDRESS <u>100 Stony Ave</u>					DATE <u>DEC 29 '61</u>				



TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

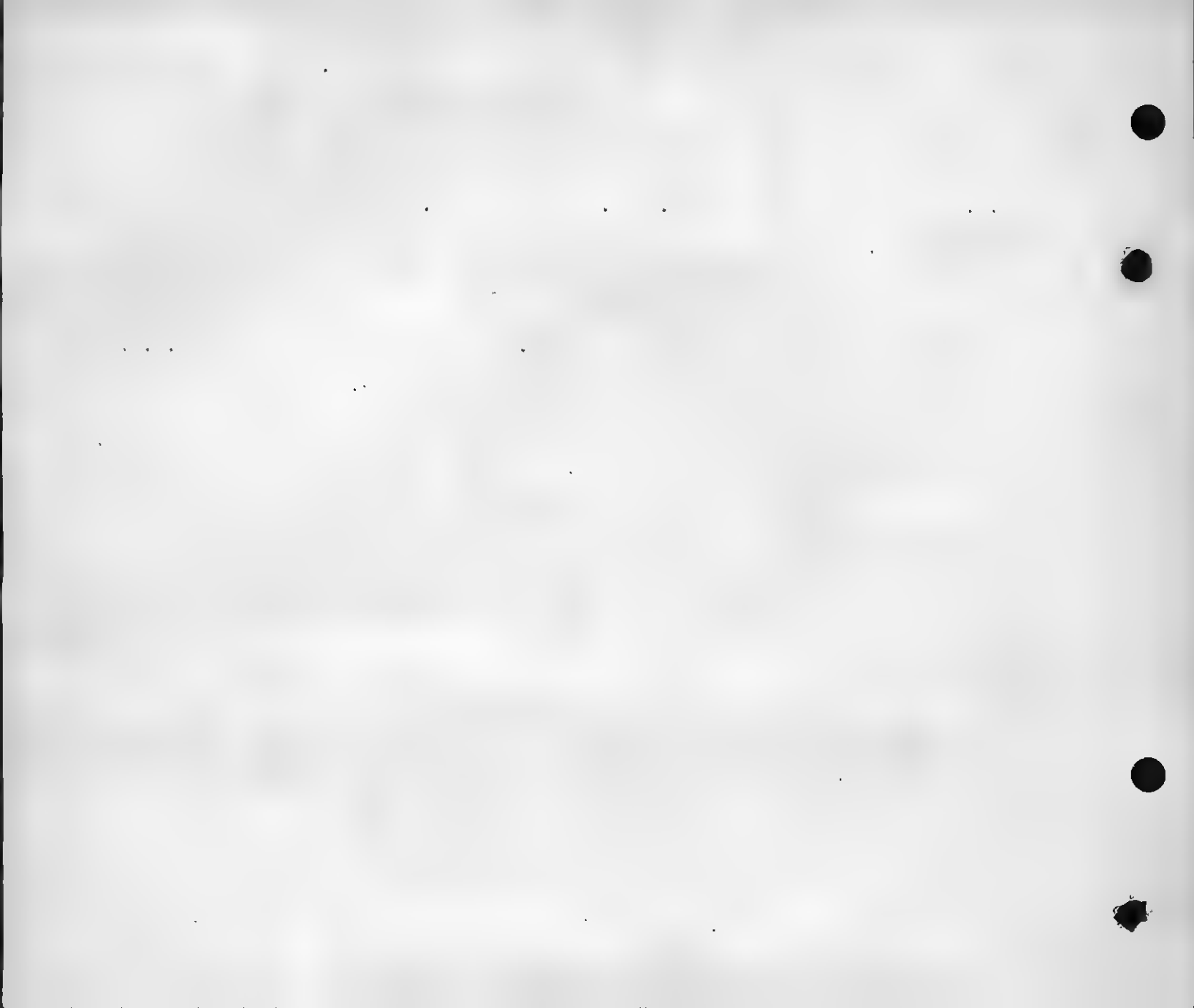
TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

# 13400 **MARYLAND STATE DEPARTMENT OF HEALTH** **DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND** **CERTIFICATE OF DEATH** 13380

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u> c. LENGTH OF STAY IN b. <u>88 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hosp</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>2711 Winchester St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Patience Brooks</u> First Middle Last <b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>Negro</u> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>12-25-81</u> <b>9. AGE</b> (in years last birthday) <u>80</u> yrs. <b>10. IF UNDER 1 YEAR</b> Months <u>0</u> Days <u>0</u> <b>11. IF UNDER 24 HRS.</b> Hours <u>0</u> Min. <u>0</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>America</u> <b>13. FATHER'S NAME</b> <u>Sam Matthews</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Lucinda Matthews</u> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> <b>16. SOCIAL SECURITY NO.</b> <u>none</u> <b>17. INFORMANT</b> <u>Heard C.S.H.</u> Address <u>none</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO (b) <u>Hypertensive Cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>none</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18) <u>none</u>			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u> <b>20f. (City or town)</b> <u>Baltimore</u> <b>(County)</b> <u>Prince Georges</u> <b>(State)</b> <u>Md</u>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>12-23-</u> <u>1961</u> , to <u>12-31-</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>12-31-</u> <u>1961</u> , and that death occurred at <u>2:00 PM</u> , from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <u>Charles W. Pope</u> <b>22b. PHYSICIAN'S NAME (Type)</b> <u>Charles W. Pope</u>		<b>22c. ADDRESS</b> <u>512 Conwelltown</u> <b>22d. ADDRESS</b> <u>512 Conwelltown</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>23b. DATE THEREOF</b> <u>1-4-62</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Int Auburn</u> <b>23d. LOCATION (City, town or county)</b> <u>Bethesda</u> <b>(State)</b> <u>Md</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Charles W. Pope</u>		<b>25a. REC'D BY REGISTRAR</b> <u>DATE JAN 4 '62</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Wm S. Thoma</u>	







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. FILL IN THIS SECTION AFTER THE DEATH CERTIFICATE IS COMPLETED BY THE ATTENDING PHYSICIAN AND COMPLETELY FILLED IN BY THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

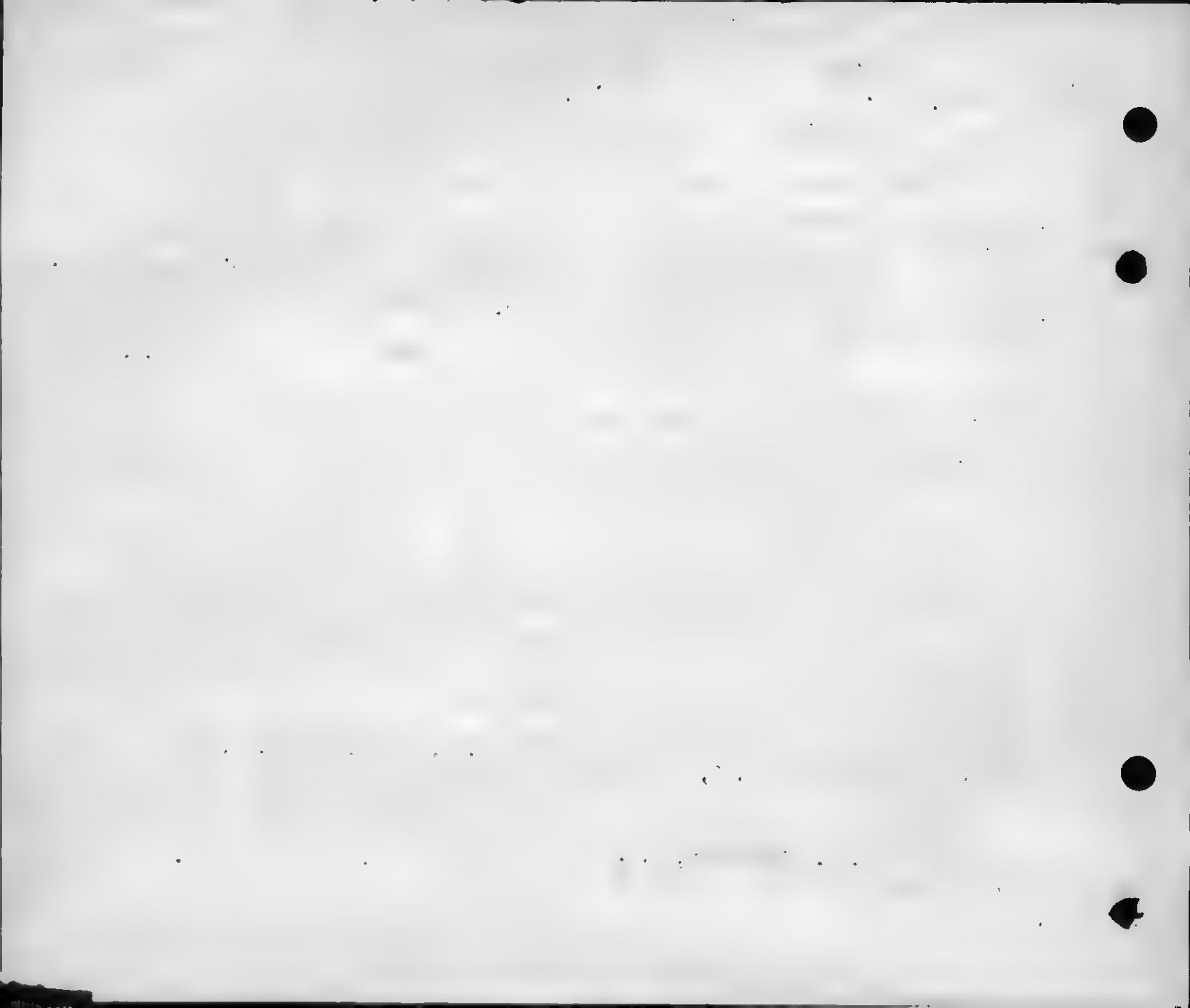
VR A15 (4)  
ISM 7 61

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <u>not present</u> attended the deceased from <u>Dec. 3, 1961</u> to <u>Dec. 3, 1961</u> , that (I) <u>not</u> last saw the deceased alive on <u>Dec. 3, 1961</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>R. L. Richardson</u>		22b. DATE SIGNED <u>12/4/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. L. Richardson, M.D.</u>		22d. ADDRESS <u>110 Clay St., Annapolis, Md.</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>buried</u>		23b. DATE THEREOF <u>12/6/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>not identified</u>		23d. LOCATION (City, town or county) (State) <u>Annapolis Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Annice A. Johnson</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 8 '61</u>	
ADDRESS <u>Annapolis</u>		25b. REGISTRAR'S SIGNATURE <u>C. S. Thomas</u>	

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
13402 Inf. from birth certificate  
CERTIFICATE OF DEATH  
13381

1. PLACE OF DEATH a. COUNTY <u>Maryland</u>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL - Arnold</u>	
c. LENGTH OF STAY IN TB <u>35 minutes</u>		d. STREET ADDRESS <u>Joyce Lane</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ellouise</u> Middle <u>BROWN</u> Last <u>BROWN</u>		4. DATE OF DEATH Month <u>December</u> Day <u>3</u> Year <u>1961</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 3, 1961</u>	
9. AGE (In years last birthday) <u>35</u>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Franklin Brown</u>		14. MOTHER'S MAIDEN NAME <u>Ellouise Day</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Address	



# FOR STATE HEALTH DEPT.

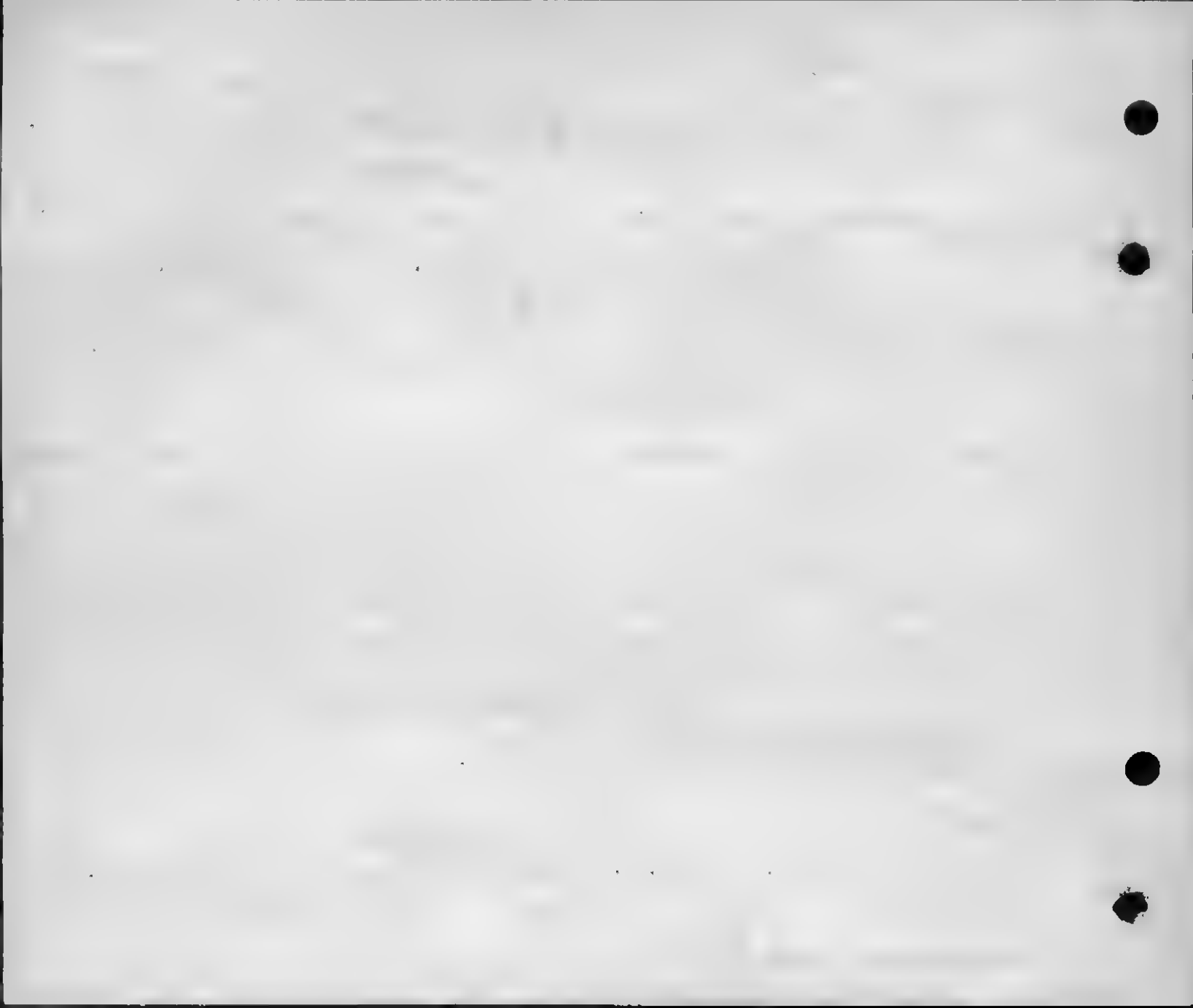
EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, the delay should be noted in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

Item 13403-1 Film 305 MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 13403 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13383

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel County,</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>15</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel Co.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		d. STREET ADDRESS <b>Best Gate Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		3. NAME OF DECEASED (Type or print) <b>WILLIAM BROWN, JR.</b>		4. DATE OF DEATH Month <b>December</b> Day <b>19</b> Year <b>1961</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-8-1922</b>		9. AGE (In years, month, day) <b>39</b> yrs. <b>11</b> months <b>8</b> days		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>8</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>add loss</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>add loss</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>William Brown</b>		14. MOTHER'S MARDEN NAME <b>Agnes E. Brown</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>213-169021</b>		17. INFORMANT <b>Mary Jones</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive and arteriosclerotic cardiovascular disease</b> DUE TO (b) <b>44-X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		21. ACTUAL SIGNATURE <b>Howard G. Shaub</b>		22. DATE THEREOF <b>December 19, 1961</b>		23. NAME OF CEMETERY OR CREMATORY <b>Brewer Hill</b>		24. LOCATION (City, town, or country) <b>Annapolis Md.</b>		25. REC'D BY REGISTRAR <b>DEC 26 '61</b>		26. REGISTRAR'S SIGNATURE <b>Clifton S. Hume</b>		27. FUNERAL DIRECTOR <b>William Reese</b>	



TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. 1. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institut on; Residence before admitt on) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>PASADENA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PASADENA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ANNE ARUNDEL GEN. HOSP.</u>		d. STREET ADDRESS <u>1 BOX 138 Rt. 10</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNE ARUNDEL</u> <u>ELIZABETH</u> <u>R. BULL</u>		4. DATE OF DEATH Month Day Year <u>DEC</u> <u>30</u> <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 9 1872</u>
9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>?</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>?</u>		Address <u>?</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA, HYPOSTATIC</u> <u>904.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>FRACTURE, SUBCAPITAL, LEFT HIP</u> (a), stating the underlying cause last. DUE TO (c) <u>DEHYDRATION</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE, SEVERE</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>FELL &amp; BROKE LEFT HIP</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>DEC. 15, 1961</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>HOME</u>		20f. (City or town) (County) (State) <u>PASADENA</u> <u>MD.</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>DEC. 15, 1961</u> to <u>DEC. 30, 1961</u> that (I) (we) last saw the deceased alive on <u>DEC. 30, 1961</u> , and that death occurred at <u>7:00 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>George Settle / G. L. Kison</u> M.D.		22b. DATE SIGNED <u>12-30-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>GEORGE SETTLE</u>		22d. ADDRESS <u>ANNE ARUNDEL GEN. HOSP.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Entombment</u>		23b. DATE THEREOF <u>1/3/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ellsworth Armacost</u>		25a. REC'D BY REGISTRAR <u>JAN 3 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			



## 13405

Reg. Dist. No. 3385

## MEDICAL CERTIFICATION



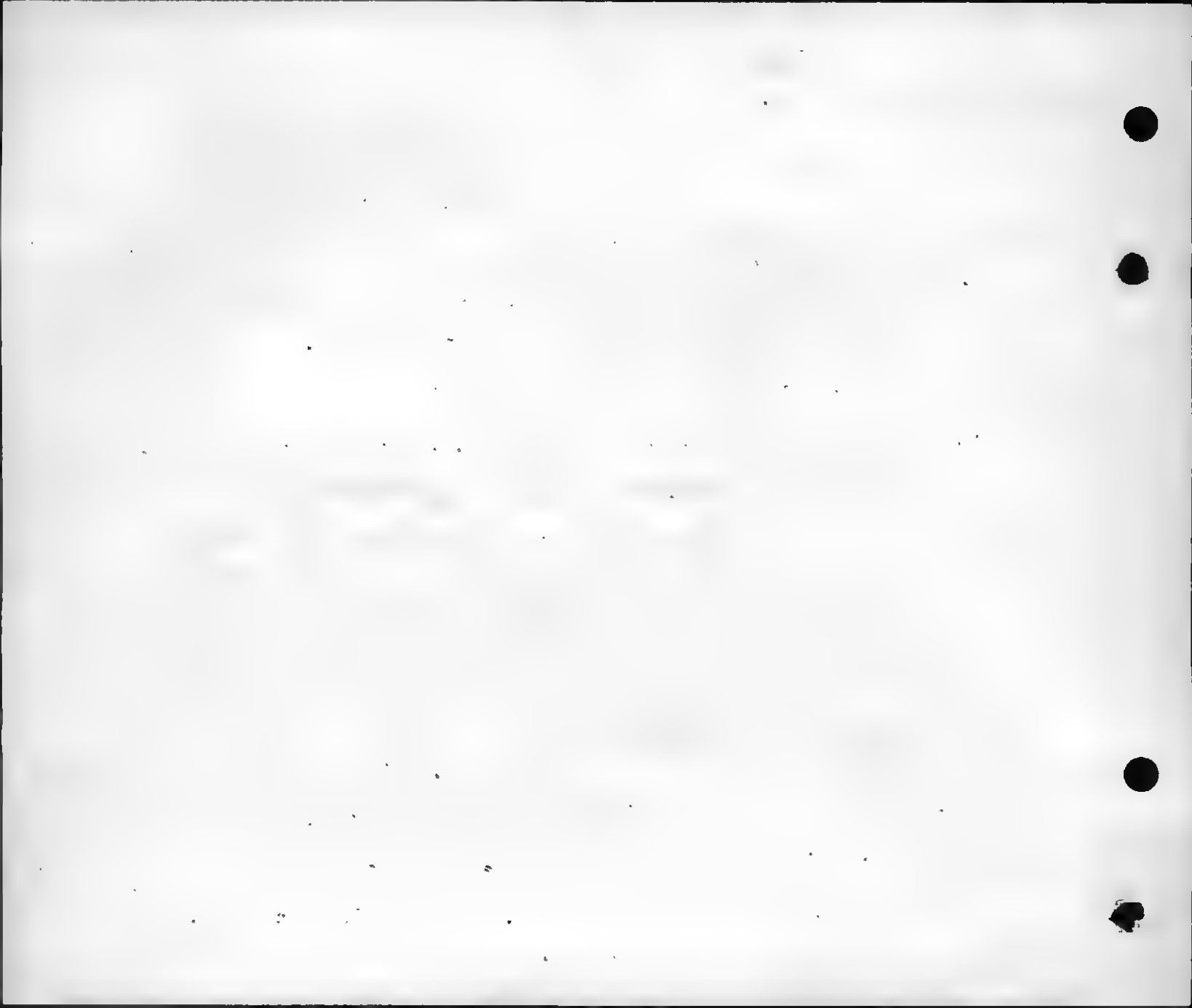
13406

## CERTIFICATE OF DEATH

Reg. Dist. 13386

1. PLACE OF DEATH a. COUNTY <u>A. Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A. Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLEN BURNIE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLEN BURNIE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>E.</u> Last <u>CALTRIDER</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>29</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 10, 1895</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	11. IF UNDER 24 HRS Hours <u>  </u> Min <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Edward Caltrider</u>		14. MOTHER'S MAIDEN NAME <u>Sophie Schaeffer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-28-7400 A</u>	
17. INFORMANT <u>Ethel E. Caltrider, 104 Summit Ave., Glen Burnie</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular disease</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March, 1960</u> to <u>Sept. 25, 1961</u> , that I last saw the deceased alive on <u>Sept. 25, 1961</u> , and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edmond I. Moushabeck</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>12/30/61</u>	
PHYSICIAN'S NAME (Type) <u>EDMOND I. MOUSHABEK</u>		<u>Glen Burnie, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-3-62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Park</u>	22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Flynn &amp; Fleming, Inc.</u>		24a. REC'D BY REGISTRAR DATE <u>2 '62</u>	
ADDRESS <u>1422 Light St.</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the attending physician and completely signed by the funeral director. After this certificate has been signed by the attending physician and completely signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13387

1 PLACE OF DEATH a. COUNTY <u>A. A.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Route 4 Box 85 B. Annapolis</u>		e. STREET ADDRESS <u>Route 4 Box 85 B.</u>	
3 NAME OF DECEASED (Type or print) <u>David D. Carr</u>		4. DATE OF DEATH Month <u>12</u> Day <u>27</u> Year <u>1961</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-19-1885</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Refused</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Carr</u>		14. MOTHER'S MAIDEN NAME <u>Harriet Carr</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Albion Spriggs R4 Box 85 B. Annapolis</u>	
17. INFORMANT <u>Albion Spriggs</u>		Address <u>R4 Box 85 B. Annapolis</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>592x</u> DUE TO <u>uremia, Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>chronic renal disease</u> DUE TO (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12-2-61</u> 19 to <u>12-27-61</u> 19, that (I) (we) last saw the deceased alive on <u>12-26-61</u> 19, and that death occurred at <u></u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>W. T. Allen</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>W. T. ALLEN</u>		22d. ADDRESS <u>61 Chestnut St</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-31-1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Broadneck</u>		23d. LOCATION (City, town, or county) <u>St. Margaret's Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u>		25a. REC'D BY REGISTRAR <u>ALBION SPRIGGS</u> 25b. REGISTRAR'S SIGNATURE <u>ALBION SPRIGGS</u>	
25c. DATE <u>12-2-61</u>		25d. TIME <u>8:00 PM</u>	



## CERTIFICATE OF DEATH

Reg. Dist. No. 13388

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> , MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Churchton</u>		c. LENGTH OF STAY IN 1b <u>2 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FRANKLIN MANOR</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Churchton</u>	
3. NAME OF DECEASED (Type or print) First <u>Laura</u> Middle <u>M.</u> Last <u>Coffman</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>22</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-22-1872</u>
9. AGE (in years lost birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William RAMBLER</u>		14. MOTHER'S MAIDEN NAME <u>SARAH KENNEDY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>AGNES S. LOUGHRY</u>		Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>  </u> DUE TO <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 14, 1959</u> to <u>Dec. 22, 1961</u> , that I last saw the deceased alive on <u>December 20, 1961</u> , and that death occurred at <u>12:40 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Willard F. Smith</u> M.D.		ADDRESS (Street, city or town, state) <u>Shady Side, Md.</u> DATE SIGNED <u>12/22/61</u>	
PHYSICIAN'S NAME (Type) <u>WILLARD F. SMITH, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town or county) (State)
<u>BURIAL</u>	<u>12-24-61</u>	<u>RIVERVIEW</u>	<u>Huntingdon</u> <u>Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Lytton</u>		ADDRESS <u>Chesapeake, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>DEC 26 '61</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR SENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

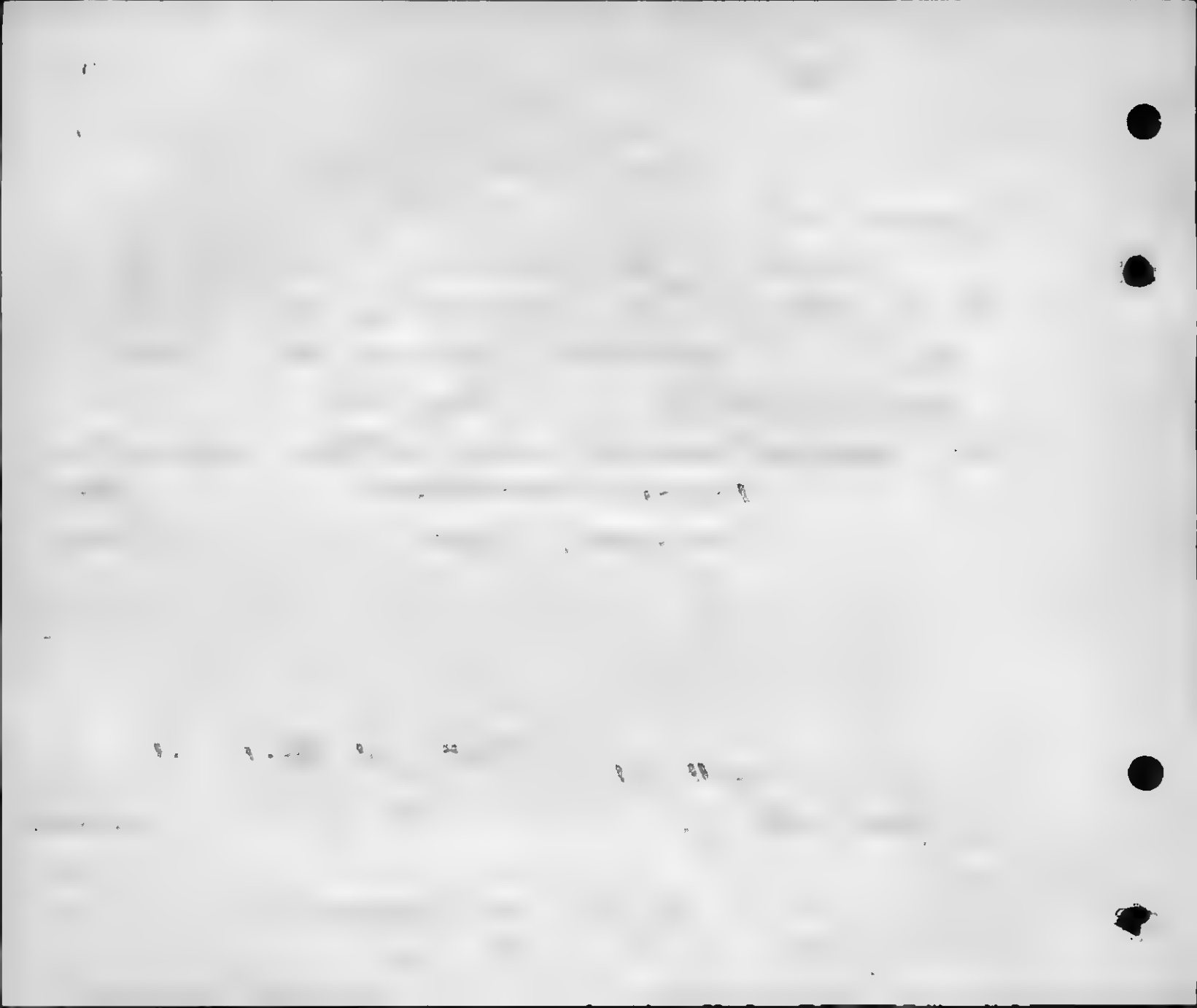
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13389

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> c. LENGTH OF STAY IN 1b <u>32 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>#10 Greenway - Marley Park</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Glen Burnie (Marley Park)</u> d. STREET ADDRESS <u>#10 Greenway</u>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Anne E. Colhouer</u>		4. DATE OF DEATH Month <u>December</u> Day <u>13</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>30th December 1906</u>		9. AGE (In years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours M.n.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Twilight Inn</u>		11c. BIRTHPLACE, County & State, or foreign country <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Archibald Hullett</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ford</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-20-7097</u>		17. INFORMANT <u>Mr. George W. Colhouer</u> Address <u>Same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>153.8</u> DUE TO <u>INTESTINAL HEMORRHAGE</u> Conditions, if any, which gave rise to immediate cause (b) <u>CARCINOMA, COLON</u> (a), stating the underlying cause last, (c) DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>INTERVAL BETWEEN ONSET AND DEATH 2 HRS. 6 MOS.</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>MARCH</u> ....., 19 <u>61</u> , to <u>DEC. 13</u> ....., 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Dec 11</u> ....., 19 <u>61</u> , and that death occurred at <u>8</u> ..M, from the causes and on the date stated above.					
22a. SIGNATURE <u>Leon C. Perry,</u>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12-15-61</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>16th Dec '61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Park</u>	
23d. LOCATION (City, town or county) <u>Glen Burnie, Maryland</u>		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Singleton</u>		ADDRESS <u>Glen Burnie, Md.</u>		25a. REC'D BY REGISTRAR <u>DEC 18 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>C. J. L. Hume</u>					



TO HOSPITAL OR TENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their pieces remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

13410

13390

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn Hgts.</u> c. LENGTH OF STAY IN 1b <u>6 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>407 Doris Ave.</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn Hgts.</u> d. STREET ADDRESS <u>407 Doris Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>3. NAME OF DECEASED</b> (Type or print) <u>MODESTA COSTA</u>		<b>4. DATE OF DEATH</b> Dec. 8, 1961		
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Oct. 4, 1896</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>11b. KIND OF BUSINESS OR INDUSTRY</b>		<b>9. AGE</b> (In years last birthday) <u>65</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>
<b>13. FATHER'S NAME</b> <u>Joseph Costa</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Gagliano</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S.</u>
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>Mr. Salvatore Costa</u>		<b>17. INFORMANT</b> <u>Same</u>
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro Vascular Thrombosis</u> DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>Diabetes Mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>4 days</u> <u>2 years</u> <u>5 years</u>
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a)</b>				
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)		
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)
<b>21. I certify that (I) (this hospital) attended the deceased from June 2, 1959 to Dec 8, 1961, that (I) (we) last saw the deceased alive on Dec 8, 1961, and that death occurred at 10:30 AM, from the causes and on the date stated above.</b>				
<b>22a. SIGNATURE</b> <u>Benjamin Berdann</u> <b>22c. PHYSICIAN'S NAME</b> (Type) <u>Benjamin Berdann M.D.</u>		<b>22b. DATE SIGNED</b> <u>Dec. 9, 1961</u>		<b>22d. ADDRESS</b> <u>5010 A. Gov. Ritchie Hwy, Balto 25, Md.</u>
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>Dec. 11, 1961</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Holy Redeemen Cemetery</u>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>George J. Gence</u> <b>ADDRESS</b> <u>4001 Ritchie Hwy. (25)</u>		<b>25a. REC'D BY REGISTRAR</b> <u>DEC 12 '61</u>		
<b>25b. REGISTRAR'S SIGNATURE</b> <u>S. T. Tiana</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The original certificate must be retained by the hospital or attending physician. The original certificate must be retained by the hospital or attending physician. The original certificate must be retained by the hospital or attending physician.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

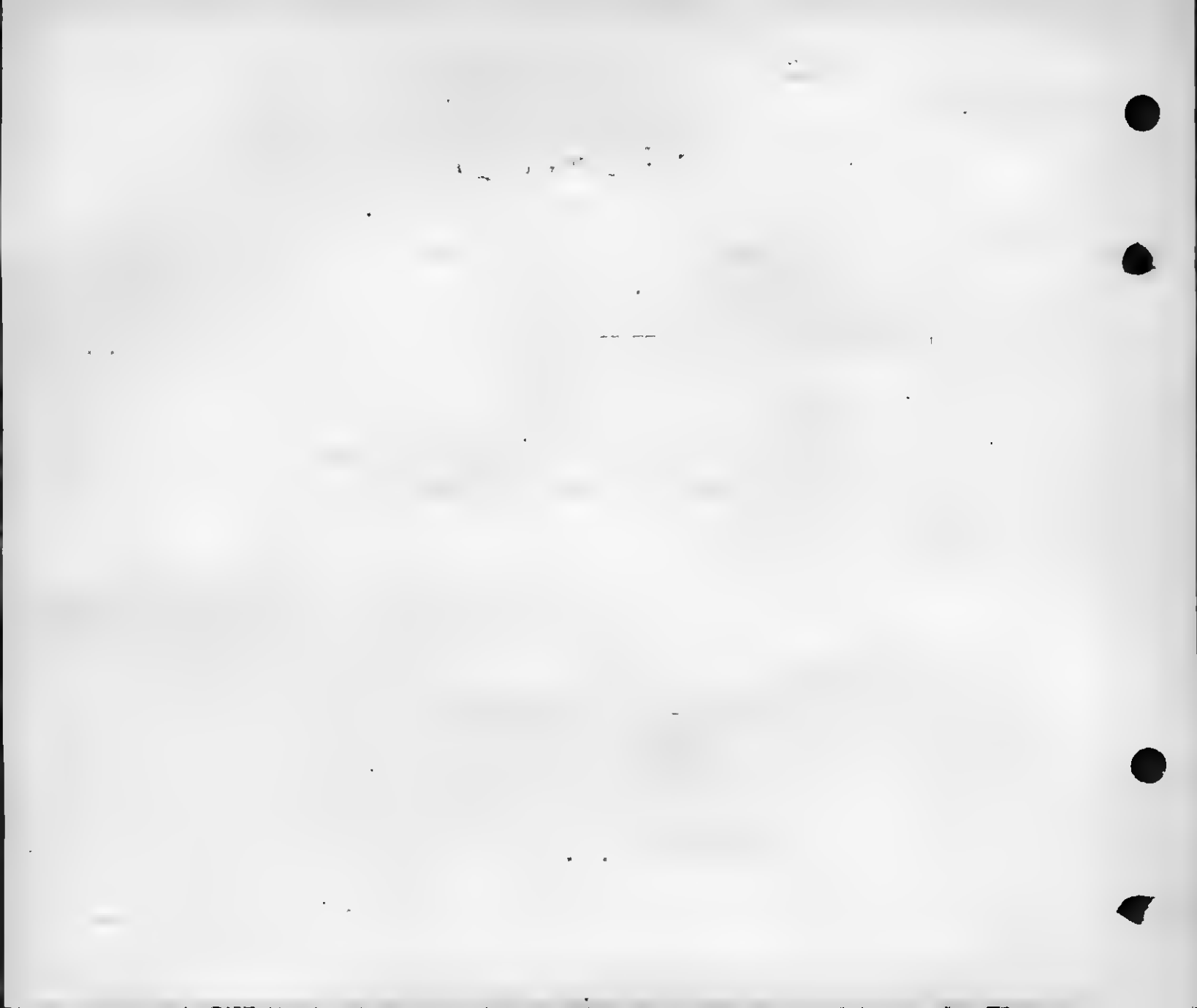
CERTIFICATE OF DEATH

13411

Item 14 Film 6303 12/22/61

13391

1 PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>1 year 6 mos. 12 days</b>		2 USUAL RESIDENCE (Where deceased lived, If institution Residence before admittance) a. STATE <b>Maryland</b>		b. COUNTY <b>Worcester</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4. DATE OF DEATH Month <b>12</b> Day <b>11</b> Year <b>19 61</b>		5 SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <b>Sep. DIVORCED <input type="checkbox"/></b>		8. DATE OF BIRTH <b>1898</b>		9 AGE (In years last birthday) yrs <b>63</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>11</b>		IF UNDER 24 HRS Hours <b>19</b> Min <b>61</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook's Helper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13 FATHER'S NAME <b>Henry Crossen</b>		14 MOTHER'S MAIDEN NAME <b>Celaine unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>Unknown</b>		17 INFORMANT <b>Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Perforating Duodenal Ulcer</b> <b>541.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. 19 WAS AUTOPSY PERFORMED? <b>Central Nervous System Syphilis</b> <b>Pneumonia</b> <b>026</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>		20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- 19 p. m. -----		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>	
20f. (City or town) <b>-----</b>		(County) <b>-----</b>		(State) <b>-----</b>					
21 I certify that (I) (this hospital) attended the deceased from <b>5/29</b> <b>1960</b> to <b>12/11</b> <b>1961</b> , that (I) (we) last saw the deceased alive on <b>12/11</b> <b>1961</b> , and that death occurred at <b>6:25 P.</b> M. from the causes and on the date stated above.									
22a. SIGNATURE <b>Lionel McHenry Mapp</b>		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE <b>12/12/61</b>		22c. PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M. D.</b>		22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>12-13-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>U. of Md. Med. School</b>		23d. LOCATION (City, town, or county) <b>Baltimore</b>		(State) <b>md.</b>	
24 FUNERAL DIRECTOR'S SIGNATURE <b>William Reese</b>		ADDRESS <b>Annapolis, Md.</b>		25a REC'D BY REGISTRAR <b>DEC 14 '61</b>		25b REGISTRAR'S SIGNATURE <b>-----</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **13392**

1. PLACE OF DEATH a. COUNTY <b>AN CO.</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>ANCO</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TRACY LANDING</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>A C H - ANNE ARUNDEL - GENERAL</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL ANNAPOLIS - MD</b>			
d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Ronald</b> Middle <b>C</b> Last <b>CROUCH</b>				4. DATE OF DEATH Month <b>12</b> Day <b>3</b> Year <b>1961</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-30-39</b>	
9. AGE (In years last birthday) <b>22 yrs.</b>		IF UNDER 1 YEAR Months <b>22</b> Days <b>22</b>		IF UNDER 24 HRS Hours <b>22</b> Min. <b>22</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>House Painting</b>			
11. BIRTHPLACE (State or foreign country) <b>Pa.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Carlyle Crouch</b>				14. MOTHER'S MAIDEN NAME <b>Mary Wolford</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>Discharge 1957</b>				16. SOCIAL SECURITY NO. <b>170-32-2899</b>			
17. INFORMANT <b>Mrs. Carlyle Crouch, Slippery Rock, Pa.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MULTIPLE INJURIES</b> 16X DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Interval between onset and death</b> (c) <b>Sudden</b> DUE TO (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>injury &amp; thrown from auto - auto accident DL 258</b>			
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b> <b>p. m.</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>E. Linhorst</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>E. Linhorst</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>12/6/61</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>West Sunbury Union Cem.</b>				22d. LOCATION (City, town, or county) (State) <b>Clay Township, Butler Co., Pa.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOPPING FUNERAL HOME</b>				24a. REC'D BY REGISTRAR <b>DEC 6 '61</b>			
ADDRESS <b>Annapolis, Maryland</b>				24b. REGISTRAR'S SIGNATURE <b>W. J. Travis</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 5 may be retained for our files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



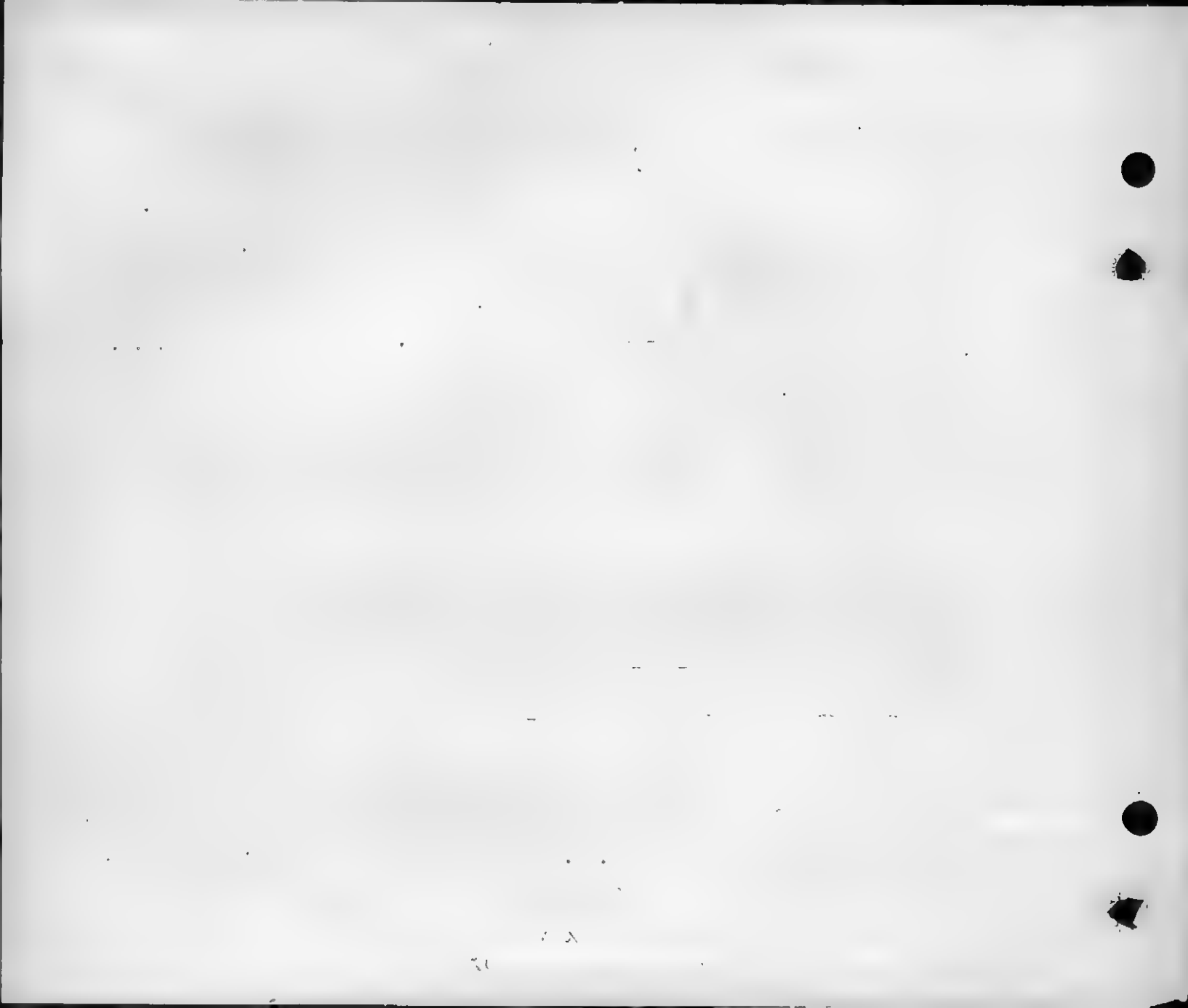
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
TO BE RETURNED TO THE HOSPITAL OR ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13413 Item 2 Film 0303 12/27/61 mh 13393

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY IN 1b <b>25 years</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived) If institution Residence before admission a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>Unknown 1012 N. Carrollton Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Robert Cure</b>		4. DATE OF DEATH Month Day Year <b>12 6 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1874</b>
9. AGE (In years last birthday) <b>87</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert Key Cure</b>		14. MOTHER'S MAIDEN NAME <b>Hannah Holland</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>334X</b> DUE TO <b>Inanition and Dehydration</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome due to Cerebral and Generalized Arteriosclerosis</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>	
20c. TIME OF INJURY Month. Day. Year Hour a. m. ----- 19 p. m. -----		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>		20f. (City or town) (County) (State) <b>-----</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>3/9</b> 19 <b>38</b> , to <b>12/6</b> 19 <b>61</b> that (I) (we) last saw the deceased alive on <b>12/6</b> 19 <b>61</b> , and that death occurred at <b>225 A.</b> from the causes and on the date stated above			
22a. SIGNATURE <b>Lionel McHenry Mapp, M. D.</b>		22b. DATE SIGNED <b>12/6/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M. D.</b>		22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL, (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/20/1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>W.H. Allman Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Mr. R. Williams</b>		25a. REC'D BY REGISTRAR <b>ST</b>	
ADDRESS <b>22 N. School St.</b>		25b. REGISTRAR'S SIGNATURE <b>Clarence L. ...</b>	
DATE <b>DEC 20 '61</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

13414

13394

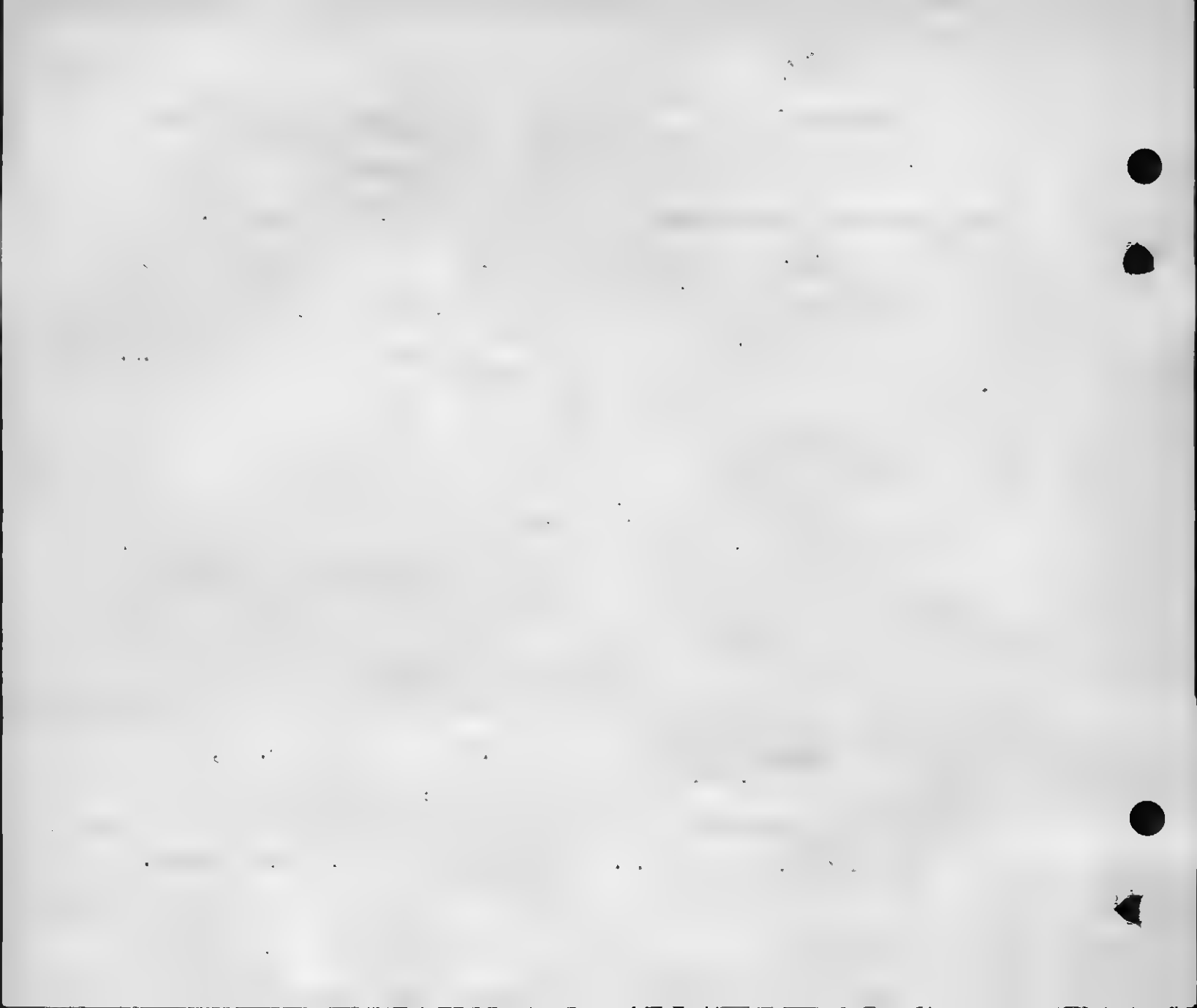
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Anne Arundel General Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> d. STREET ADDRESS <b>239 Prince George St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Charles</b> Middle <b>P.</b> Last <b>DALTON</b>		<b>4. DATE OF DEATH</b> Month <b>December</b> Day <b>19</b> Year <b>1961</b>	
<b>5. SEX</b> <b>Male</b> <b>6. COLOR OR RACE</b> <b>White</b> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>April 22, 1909</b> <b>9. AGE</b> (In years last birthday) <b>52 yrs.</b> <b>10. FUNDER 1 YEAR</b> Months <b>0</b> Days <b>0</b> <b>11. IF UNDER 24 HRS.</b> Hours <b>0</b> M. n. <b>0</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>PERFECTER</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>U.S. GOVT</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Alabama</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.</b>	
<b>13. FATHER'S NAME</b> <b>CHARLES P. DALTON</b> <b>14. MOTHER'S M.A.DEN NAME</b> <b>ERIE SINGLETON</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>yes</b> <b>16. SOCIAL SECURITY NO.</b> <b>17. INFORMANT</b> <b>LUCILLE DALTON</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized peritonitis and aspiration of hemodysic gastric content with large perforated duodenal ulcer with general peritonitis and massive gastric hemorrhage</b> (b) <b>541.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <b>Perforated duodenal ulcer with general peritonitis and massive gastric hemorrhage</b> (c) <b>Cirrhosis of the liver</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>72 hours</b> <b>72 hours</b>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18)		<b>20c. TIME OF INJURY</b> Month, Day, Year <b>19</b> Hour a.m. <b>12:05 AM</b> p.m. <b>12:05 AM</b> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>77 Franklin St., Annapolis, Md.</b> <b>20f. (City or town)</b> <b>Annapolis</b> <b>(County)</b> <b>Anne Arundel</b> <b>(State)</b> <b>Md.</b>	
<b>21. I certify that (I) (the doctor) attended the deceased from Dec. 16, 1961 to Dec. 18, 1961 that (I) saw the deceased alive on Dec. 18, 1961, and that death occurred at M. from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <b>Barber C. Palmer, M.D.</b> <b>22c. PHYSICIAN'S NAME (Type)</b> <b>Barber C. Palmer, M.D.</b>		<b>22b. DATE SIGNED</b> <b>12/19/61</b>	
<b>23a. BURIAL, CREMATION, 23b. DATE THEREOF</b> <b>Burial 12-20-1961</b> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Hillcrest Memorial</b> <b>23d. LOCATION (City, town or county)</b> <b>Annapolis</b> <b>(State)</b> <b>Md.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DEC 22 '61</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Evans</b>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



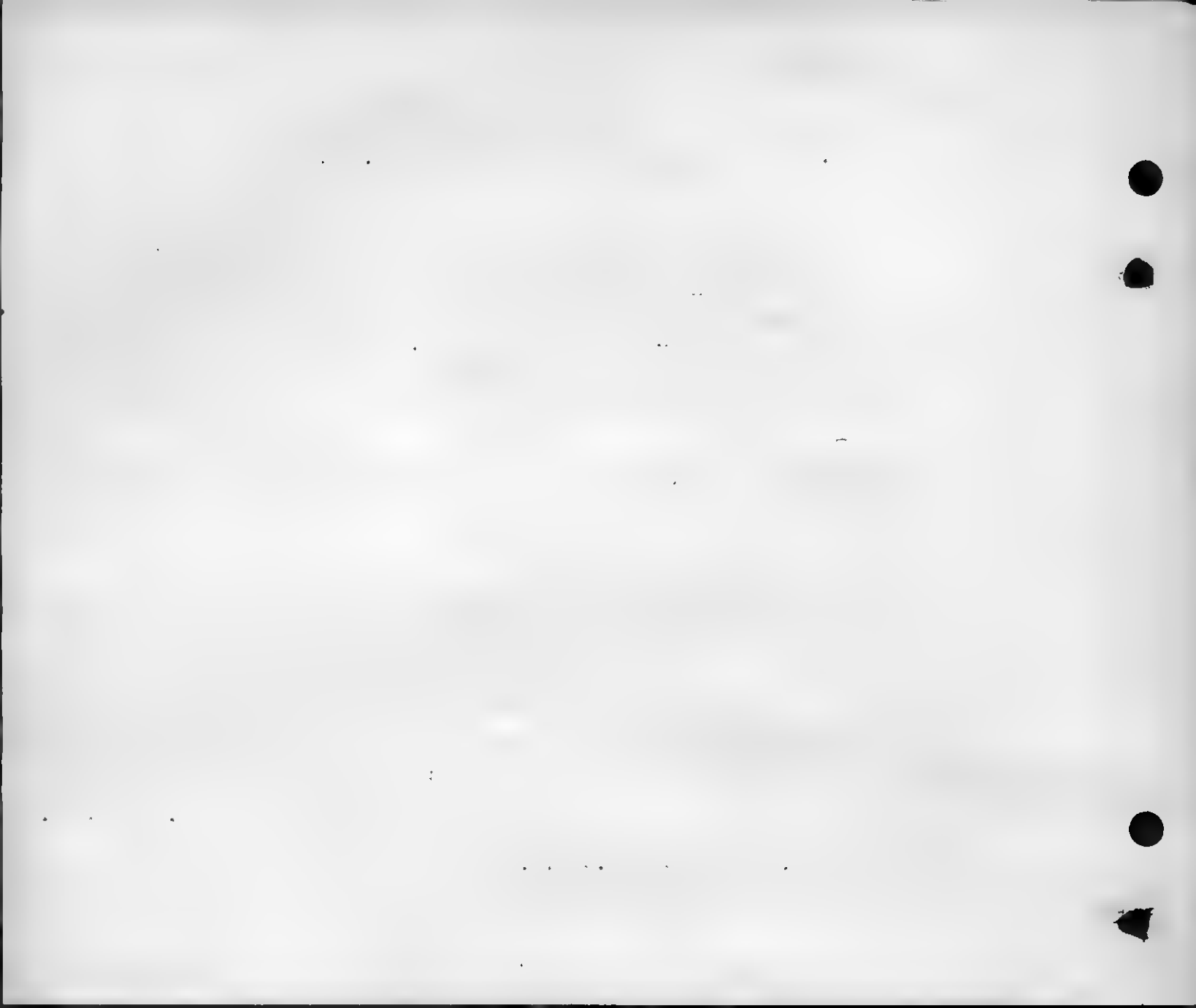
CERTIFICATE OF DEATH

13415

Reg. Dis. 18395

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kimborough Army Hospital</u>		d. STREET ADDRESS <u>Qtrs # 1819-B Meade Heights</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CENTY</u> Middle <u>L.</u> Last <u>DAVIS</u>		4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>10</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12 Jan 58</u>
9. AGE (In years last birthday) yrs. <u>3</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>  </u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland Cumberland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ernest Davis</u>		14. MOTHER'S MAIDEN NAME <u>Anna Horwath</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>  </u>		16. SOCIAL SECURITY NO <u>  </u>	
17. INFORMANT <u>Father</u>		Address <u>Same as item 2d</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cystic Fibrosis</u> DUE TO (c) <u>Congenital</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>61</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I attended the deceased from <u>7 Dec</u> , 19 <u>61</u> , to <u>10 Dec</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>10 Dec</u> , 19 <u>61</u> , and that death occurred at <u>10:30 A.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sherman S. Robinson</u> M.D.		ADDRESS (Street, city or town, state) <u>Kimborough Army Hosp Ft Geo Meade, Md.</u>	
DATE SIGNED <u>  </u>			
PHYSICIAN'S NAME (Type) <u>SHERMAN S. ROBINSON, Capt., M.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 14, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Davis Memorial Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli</u>		ADDRESS <u>Cumberland, Md.</u>	
24a. REC'D BY REGISTRAR <u>DEC 18 '61</u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13416

## CERTIFICATE OF DEATH

13396

### 1. PLACE OF DEATH

a. COUNTY

Anne Arundel

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Crownsville

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Crownsville State Hospital

### 3. NAME OF DECEASED

(Type or print)

Nathan

### 5. SEX

Male

### 6. COLOR OR RACE

Negro

### 7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

### 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

a. STATE

Maryland

b. COUNTY

Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Kensington

d. STREET ADDRESS

10717 Shantsberry St.

Last

First

Month

Day

Year

DATE OF DEATH

12

16

1961

### 8. DATE OF BIRTH

April 15, 1878

### 9. AGE (In years last birthday)

83 yrs

### IF UNDER 1 YEAR

Months Days Hours Min.

### IF UNDER 24 HRS.

Hours Min.

### 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Gardner

### 10b. KIND OF BUSINESS OR INDUSTRY

-----

### 11. BIRTHPLACE (County & State, or foreign country)

Clarksberg, Maryland

### 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

### 13. FATHER'S NAME

Rinaldo Davis

### 14. MOTHER'S MAIDEN NAME

Minerva Snowden

### 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

### 16. SOCIAL SECURITY NO

577-20-9377

### 17. INFORMANT

Hospital Records

### Address

### 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

#### PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

DUE TO

Hypostatic Bronchopneumonia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

Arteriosclerotic Cardiovascular Disease

(c)

#### PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

Fecal Impaction

### INTERVAL BETWEEN ONSET AND DEATH

### 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

### 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of form 18.)

### 20c. TIME OF INJURY

Month, Day, Year

### 20d. INJURY OCCURRED

While at work ☐ Not While at work ☒

### 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

### 20f. (City or town)

### (County)

### (State)

### 21. I certify that (I) (this hospital) attended the deceased from.

3/18

19 57

to 12/16

19 61

that (I) (we) last saw the deceased alive on 12/16 19 61 and that death occurred at 3:30 P.M. from the causes and on the date stated above.

### 22a. SIGNATURE

Hildegard Heard Reissman

M.D.

### ATTENDING PHYS.

☒

### MED. DIRECTOR

☐

### STAFF PHYS.

☐

### 22c. PHYSICIAN'S NAME (Type)

Hildegard Heard Reissman, M. D.

### 22d. ADDRESS

Crownsville State Hospital, Maryland

### 22b. DATE SIGNED

12/18/61

### 23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

12/21/61

### 23c. NAME OF CEMETERY OR CREMATORY

Brewer Hill

### 23d. LOCATION (City, town or county)

### (State)

Annapolis, Maryland

### 24 FUNERAL DIRECTOR'S SIGNATURE

C. E. Hicks, III

### ADDRESS

Annapolis, Maryland

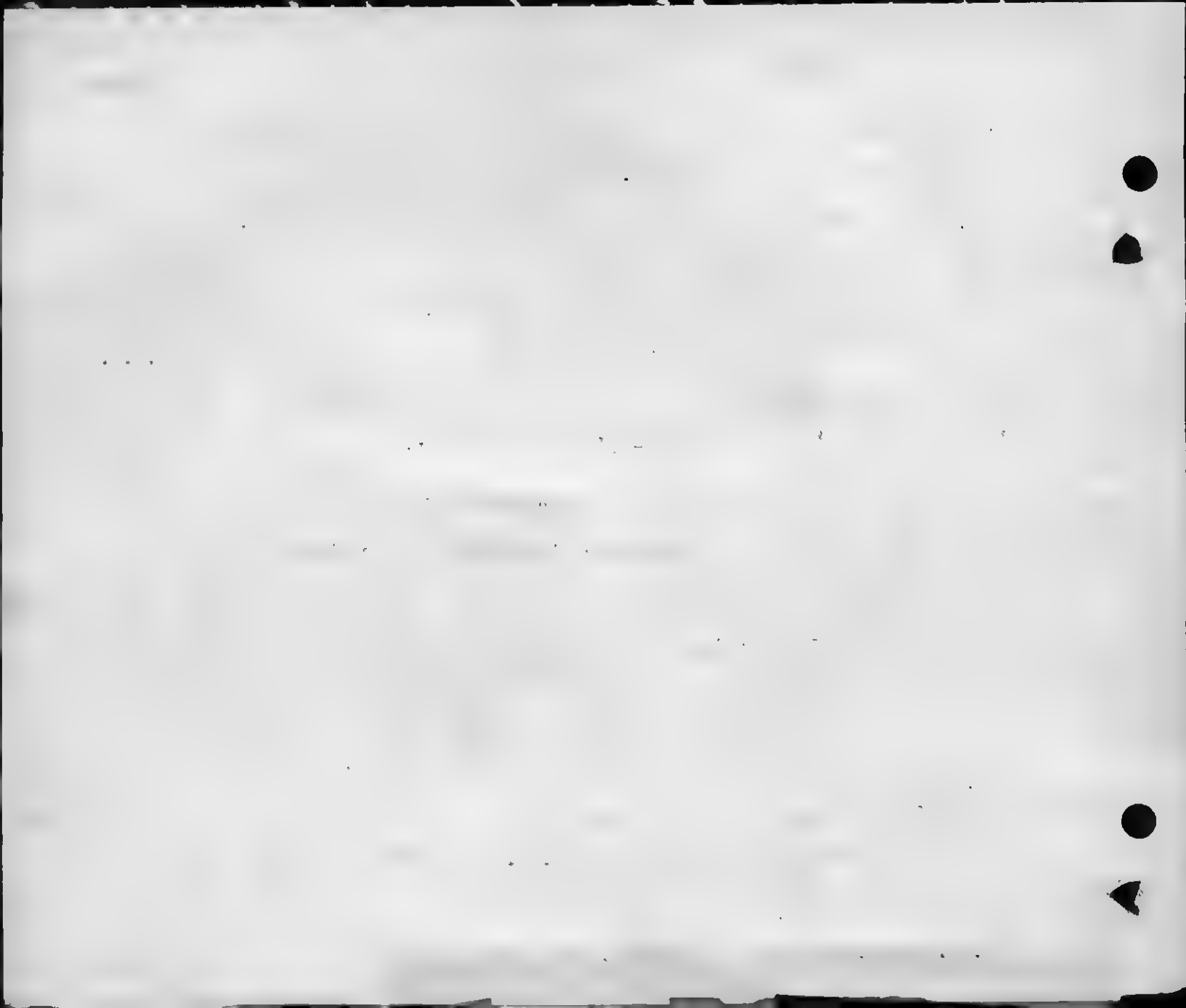
### 25a. REC'D BY REGISTRAR

DATE DEC 22 '61

### 25b. REGISTRAR'S SIGNATURE

W. L. S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

13417

13397

1. PLACE OF DEATH a. COUNTY <u>aa</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>aa</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arnold</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Arnold</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>R. F. D.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Robert</u> Last <u>Daywalt</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>9</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-14-1885</u>	9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Director of School for AA6 Md.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hagerstown Md</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>-</u>			
17. INFORMANT <u>Caroline S. Daywalt</u> Address <u>(2)</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of prostate</u> DUE TO <u>177X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>metastatic to bone</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>1 yr. 6 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> 19 <u>61</u> , to <u>12-9</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>12-5-1961</u> , and that death occurred at <u>7 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Frank M. Shipley</u> M.D.				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>12-11-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>FRANK M. SHIPLEY</u>				22d. ADDRESS <u>Arnold Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-12-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cashway Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Arnold Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Shipley Sr.</u> ADDRESS <u>Arnold Md.</u>				25a. REC'D BY REGISTRAR <u>13 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	





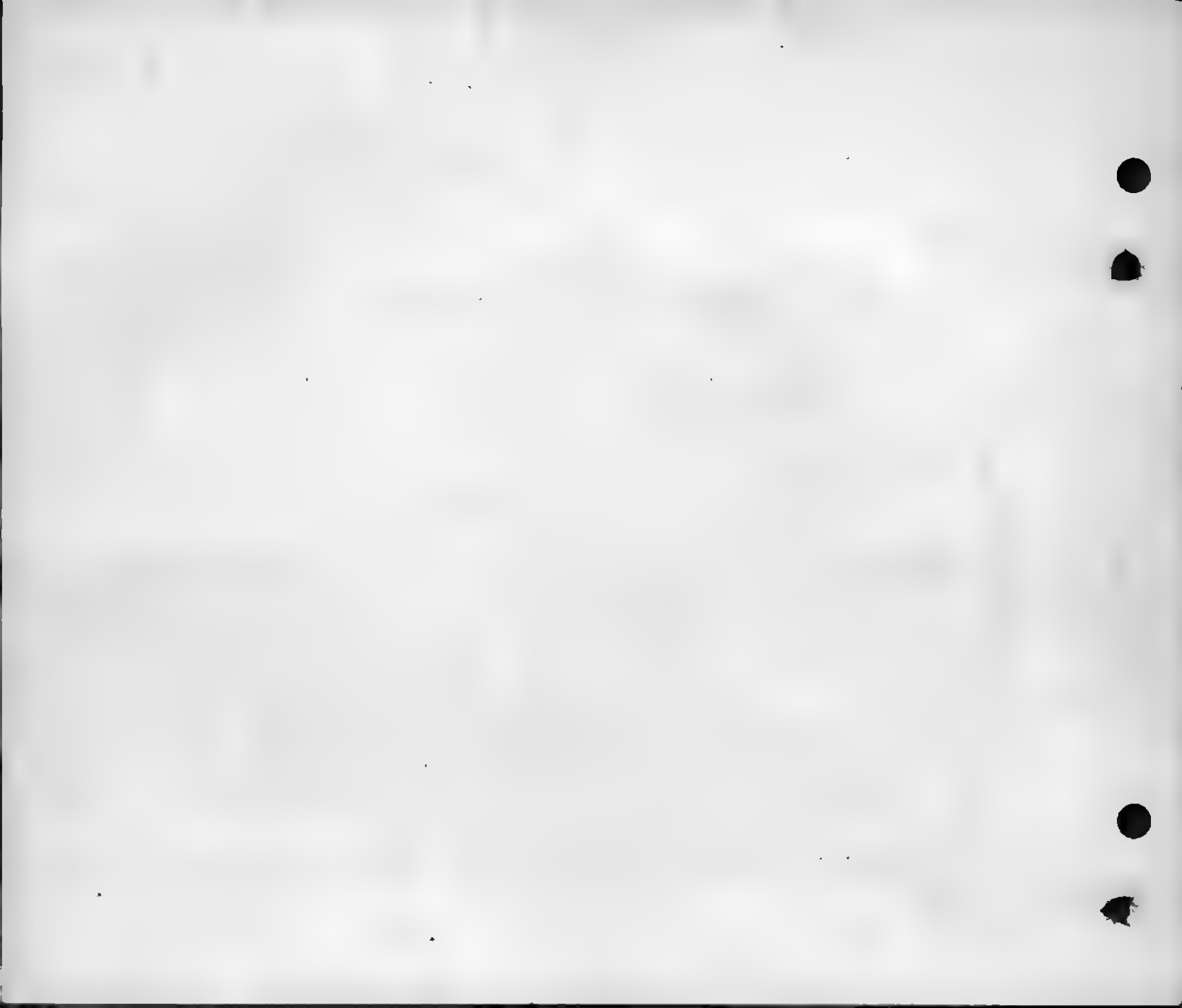
13418

CERTIFICATE OF DEATH

Reg. Dist. No. 13398

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rt. 9, box 71</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Franklin</u> Middle <u>DEAN</u> Last <u>Jr.</u>				4. DATE OF DEATH Month <u>December</u> Day <u>3</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-12-61</u>	
9. AGE (In years last birthday) --- yrs.		10. AGE (In years last birthday) <u>5</u> yrs.		11. AGE (In years last birthday) <u>20</u> yrs.		12. AGE (In years last birthday) <u>20</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>				10b. KIND OF BUSINESS OR INDUSTRY -----			
11. BIRTHPLACE (State or foreign country) <u>Maryland (Anne Arundel Co.)</u>				12. CITIZEN OF WHAT COUNTRY? -----			
13. FATHER'S NAME <u>Franklin Dean Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Alicetina Day</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. -----		17. INFORMANT <u>Mother-same address</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Viral Pneumonia</u> <u>492X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>No injury.</u>					
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-3</u> , 19 <u>61</u> , to <u>present</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>12-3</u> , 19 <u>61</u> , and that death occurred at <u>8.20 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H-F Manuzak</u>				ADDRESS (Street, city or town, state) <u>425 S. Ritchie Hwy</u>			
PHYSICIAN'S NAME (Type) <u>H.F. Manuzak, M.D.</u>				DATE SIGNED <u>3 Dec 1961</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/7/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Magothy Cemetary</u>		22d. LOCATION (City, town, or county) (State) <u>Anns Arundel Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Elroy O. Wilson</u>				24a. REC'D BY REGISTRAR <u>DEC 6 '61</u>		24b. REGISTRAR'S SIGNATURE <u>W. S. Kline</u>	

NOTE: The child was seen by Dr Elroy O. Wilson on 12-3-61



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any case, within 72 hours after death.

1.

M

13419

MARYLAND STATE DEPARTMENT OF HEALTH

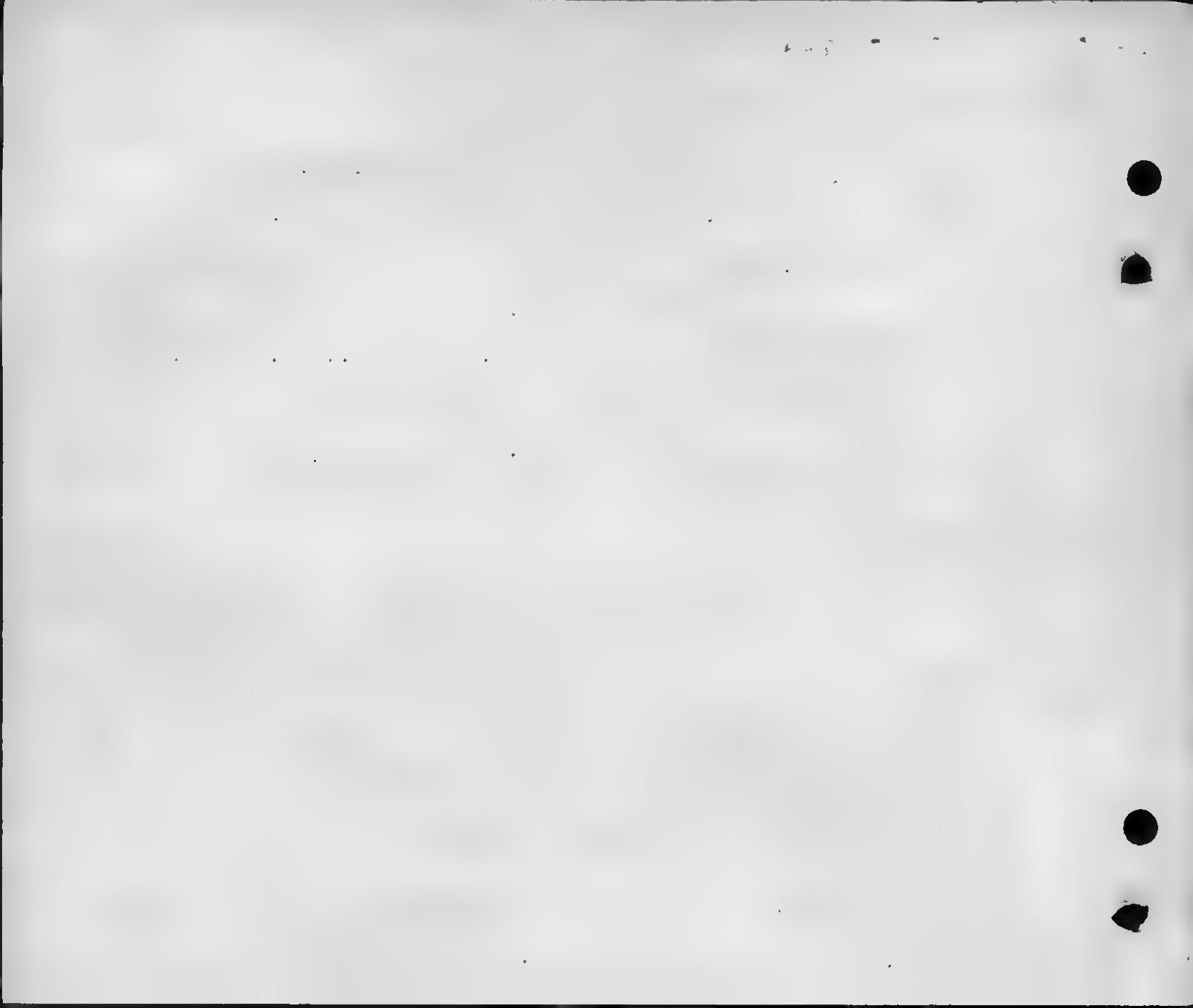
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13399

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Brooklyn, Md.</u> <u>210 Hillcrest Ave.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>Brooklyn, Md.</u> <u>210 Hillcrest Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Leila M. Dean</u>		4. DATE OF DEATH <u>12/8/61</u> Month <u>12</u> Day <u>8</u> Year <u>1961</u>	
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 16, 1885</u> Last <u>16</u> Month <u>1</u> Day <u>1885</u>	
9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) <u>76</u> yrs. <u>12</u> months <u>8</u> days <u>19</u> hours <u>15</u> min.		10. BIRTHPLACE (County & State, or foreign country) <u>St. Marys Co., Md.</u>	
11. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Owing Joy</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Dean</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>none</u>	
17. INFORMANT <u>Mrs. Benson Dean</u>		Address <u>3608 Hineline Rd. #29</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured Abdominal Aneurysm</u> <u>451X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic Aorta</u> (c), stating the underlying cause last. <u>Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>10 years</u> <u>15 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 1, 1955</u> , to <u>Dec. 8, 1961</u> , that (I) (we) last saw the deceased alive on <u>Dec. 8, 1961</u> , and that death occurred at <u>2:15 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Benjamin Birdann</u>		22b. DATE SIGNED <u>Dec 8 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>BENJAMIN BIRDANN</u>		22d. ADDRESS <u>3010 A Ritchie Highway</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/11/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Elkridge, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Howard H. Hubbard</u>		25a. REC'D BY REGISTRAR <u>DEC 12 '61</u>	
ADDRESS <u>4107 Wilkens Ave.</u>		25b. REGISTRAR'S SIGNATURE	

VR A15 (4)  
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13420

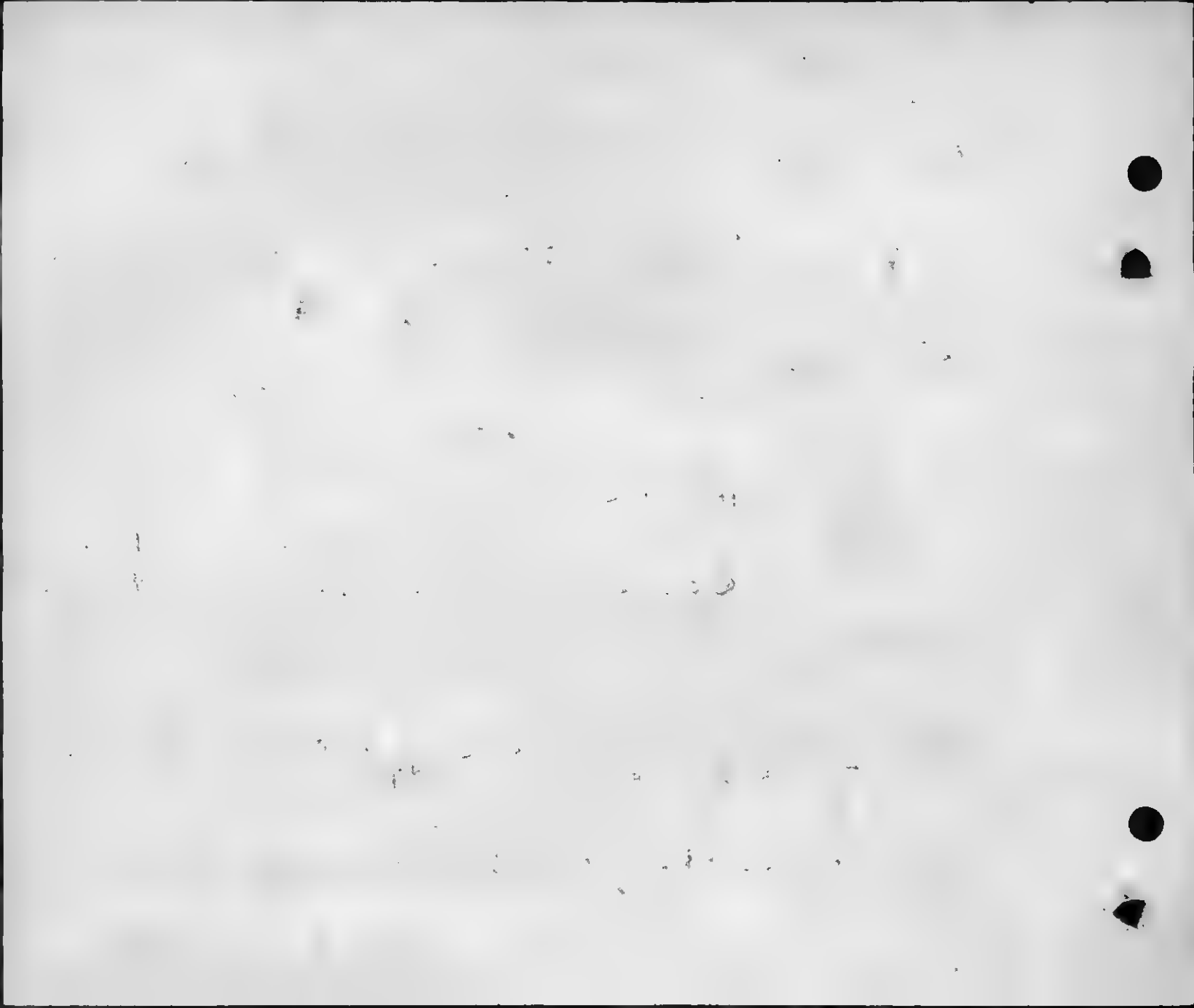
CERTIFICATE OF DEATH

13460

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LIEN BURNIE</u>		c. LENGTH OF STAY IN 1b <u>3 Yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Plaza Manor Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Isaiah Dennis</u>		4. DATE OF DEATH Month Day Year <u>December 9 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JANUARY 14, 1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>fishing</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO <u>unknown</u>	
17. INFORMANT <u>Martha L Prann</u>		Address <u>AA Co. D.P.W.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>malnutrition</u> 422.1 DUE TO (b) <u>spasm of pharynx</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>cardiovascular disease with recurrent C.V.A.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>optic Atrophy - Hypertrophic Arthritis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11-19-1960</u> to <u>12-9-1961</u> , that (I) (we) last saw the deceased alive on <u>12-9-1961</u> , and that death occurred at <u>5:00 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>James M. Pair</u>		22b. DATE SIGNED <u>12-10-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>James M. Pair - M.D.</u>		22d. ADDRESS <u>4400 N. Carrollton Ave - Balto 23</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12-13-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Matthews</u>	23d. LOCATION (City, town, or county) (State) <u>Shedyside Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u>		25a. REC'D BY REGISTRAR <u>Anna M. D.</u>	
25b. REGISTRAR'S SIGNATURE <u>Anna M. D.</u>		DATE <u>DEC 13 61</u>	







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

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10  
1  
2

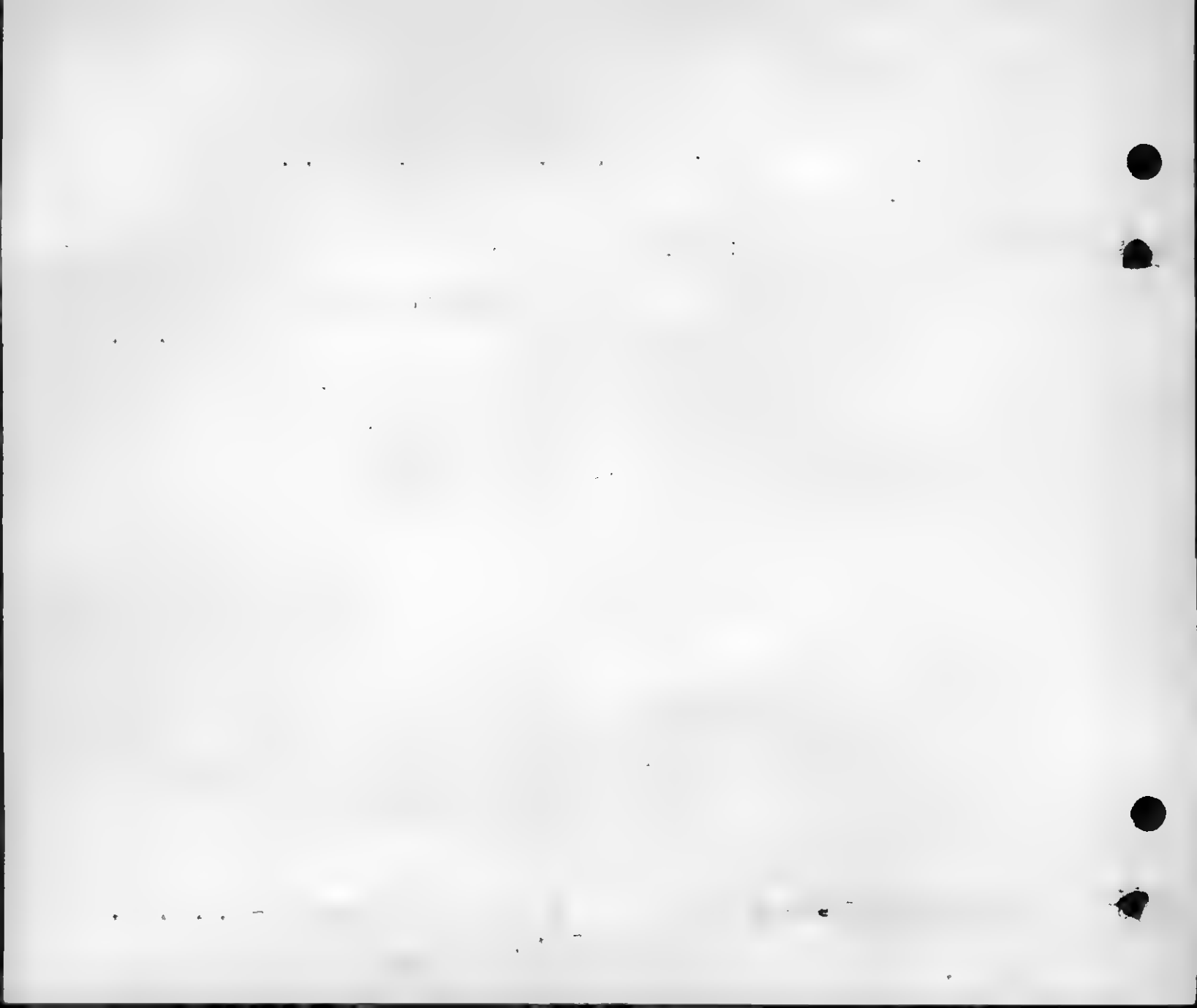
13422

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13402

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville, Md</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Tucker Lane, Ednor P.O., Maryland</b>	
c. LENGTH OF STAY IN 1b <b>8 y, 8 mo, 11 d</b>		d. STREET ADDRESS <b>1515-A</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary Lillian</b> Middle <b>Dockett</b> Last <b>Dockett</b>		4. DATE OF DEATH Month <b>12</b> Day <b>26</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/16/1897</b>
9. AGE (In years last birthday) <b>64</b>		10. IF UNDER 1 YEAR: Months <b>6</b> Days <b>10</b> Hours <b>15</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Wesley Dockett</b>		14. MOTHER'S MAIDEN NAME <b>Annie Ford Dockett</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Tuberculosis of lungs</b> DUE TO (b) <b>002</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>X</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>002</b> INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4/15</b> 19 <b>53</b> to <b>12/26</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>12/26</b> 19 <b>61</b> , and that death occurred at <b>7:45am</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Edgar Heard Reim</b> M.D.		22b. DATE SIGNED <b>12/26/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edgar Heard Reim</b>		22d. ADDRESS <b>Crownsville State Hospital</b>	
23a. BURIAL, CREMATION <b>BURIAL</b> DATE THEREOF <b>12-29-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>JOHN WESLEY ANNAPOLIS-Md.</b>	
23d. LOCATION (City, town, or county) (State) <b>WATERBURY - A.A.Co. Md.</b>		25a. REC'D BY REGISTRAR <b>DATE JAN 5 '62</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>G. E. Nucko. 111 43-45 North Ave. ST</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Haines</b>	



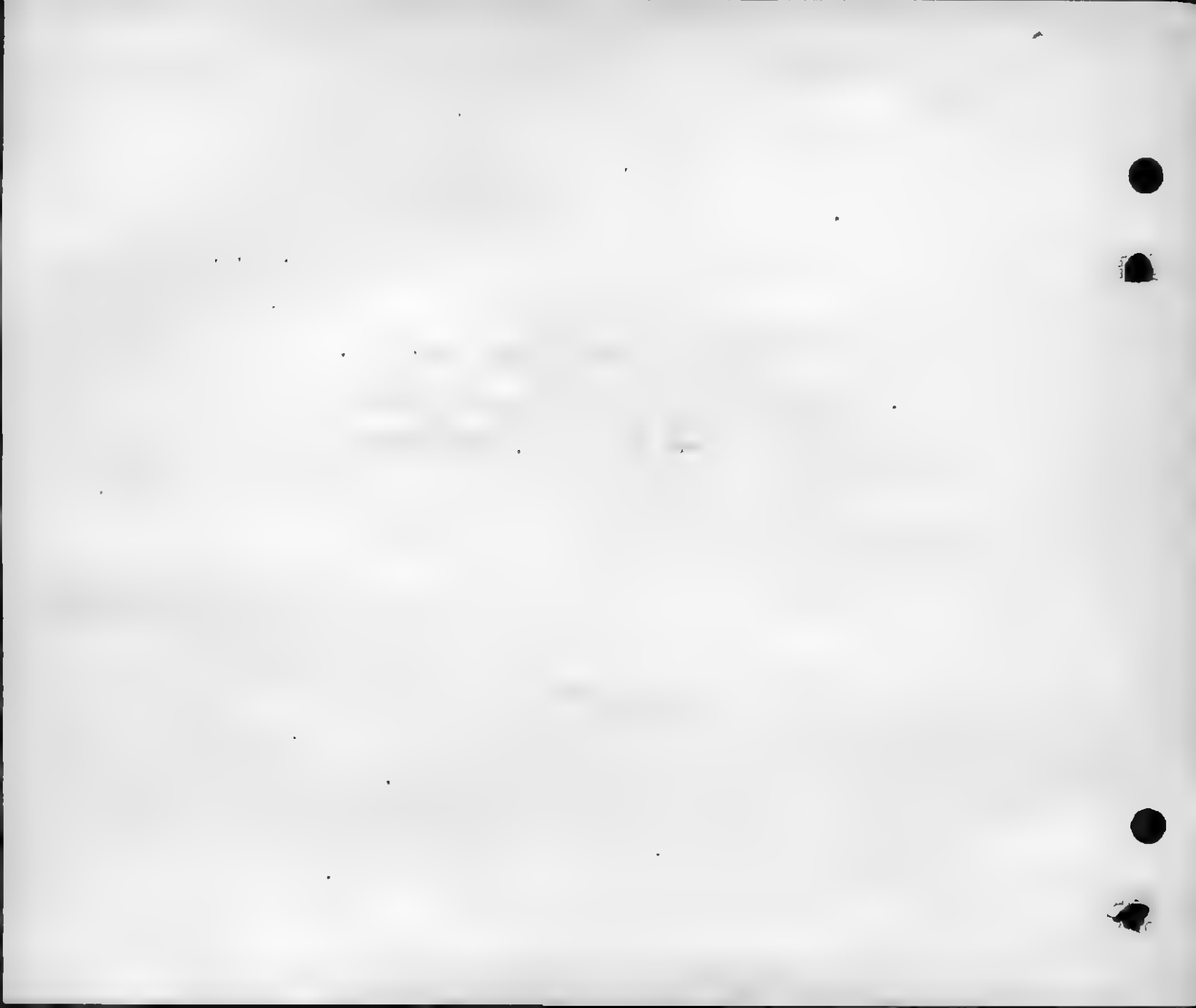
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4  
 be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

13423

13403

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Same</b> b. COUNTY <b>Same</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Same</b>			
c. LENGTH OF STAY IN 1b <b>17 y.</b>				d. STREET ADDRESS <b>Samr</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>18 Highland Rd. Marley Park</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Edward L.</b> Middle <b>Driver</b> Last <b>Driver</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>10th.</b> Year <b>1961</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/15/11</b>		9. AGE (In years last birthday) <b>50y.</b> yrs.	IF UNDER 1 YEAR Months <b>50</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Butcher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Corkran Hill &amp; Co. Baltimore Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Frank T. Driver</b>				14. MOTHER'S MAIDEN NAME <b>Hattie Grace</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>215-49-9528</b>		17. INFORMANT <b>Mrs. Hattie Driver Mabel Driver (wife)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>DUE TO</b> (c) <b>DUE TO</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11/27/61</b> 19 to <b>12/10/61</b> 19, that (I) (we) last saw the deceased alive on <b>12/4/61</b> 19, and that death occurred at <b>7 AM</b> , from the causes and on the date stated above				22b. DATE SIGNED <b>12/10/61</b>			
22a. SIGNATURE <b>Gustave H. Faubert, M.D.</b>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22d. ADDRESS <b>Glen Burnie, Md.</b>			
22c. PHYSICIAN'S NAME (Type) <b>Gustave H. Faubert, M.D.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>12-14-61</b>		23b. DATE THEREOF <b>12-14-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Johnson</b>				25a. REC'D BY REGISTRAR DATE <b>12/12/61</b>		25b. REGISTRAR'S SIGNATURE <b>12/12/61</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

13424

13104

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> <span style="float: right;">c. LENGTH OF STAY IN 1b <u>35 minutes</u></span> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Anne Arundel</u></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL - Edgewater</u> d. STREET ADDRESS <u>Rt-3, Box-189</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Baby Girl</u> First Middle Last		<b>4. DATE OF DEATH</b> <u>December 11 1961</u> Year Month Day		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <u>Dec. 11, 1961</u>		<b>9. AGE (in years last birthday)</b> IF UNDER 1 YEAR: Months <u>11</u> Days <u>35</u> IF UNDER 24 HRS. Hours <u>35</u> Min. <u>35</u>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)			
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>		<b>13. FATHER'S NAME</b> <u>James W. Duckett</u>			
<b>14. MOTHER'S MAIDEN NAME</b> <u>Jean Isaac</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service)		<b>16. SOCIAL SECURITY NO.</b>			
<b>17. INFORMANT</b> <u>Hospital Records</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Extreme prematurity</u> DUE TO (b) <u>776</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>35 min</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b> (County) (State)		<b>21. I certify that (I) (Doctor) attended the deceased from Dec. 11, 1961 to Dec. 11, 1961, that (I) saw the deceased alive on Dec. 11, 1961, and that death occurred at 2:00 AM from the causes and on the date stated above.</b>					
<b>22a. SIGNATURE</b> <u>Robert A. Riley, Jr., M.D.</u>		<b>22b. DATE SIGNED</b> <u>12/11/61</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Robert A. Riley, Jr., MD</u>			
<b>22d. ADDRESS</b> <u>69 Franklin St., Annapolis, Md.</u>		<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>					
<b>23b. DATE THEREOF</b> <u>Dec. 11, 1961</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Davidsonville Methodist</u>		<b>23d. LOCATION (City, town or county)</b> <u>Davidsonville, Md.</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Hopping Funeral Home</u>		<b>24a. REGISTERED BY REGISTRAR</b> <u>DATE DEC 13 '61</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>C. L. H. HARRIS</u>			
<b>24c. ADDRESS</b> <u>Annapolis, Md.</u>							

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. The certificate must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60

6263192XV



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
be retained at the hospital or attending physician.  
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

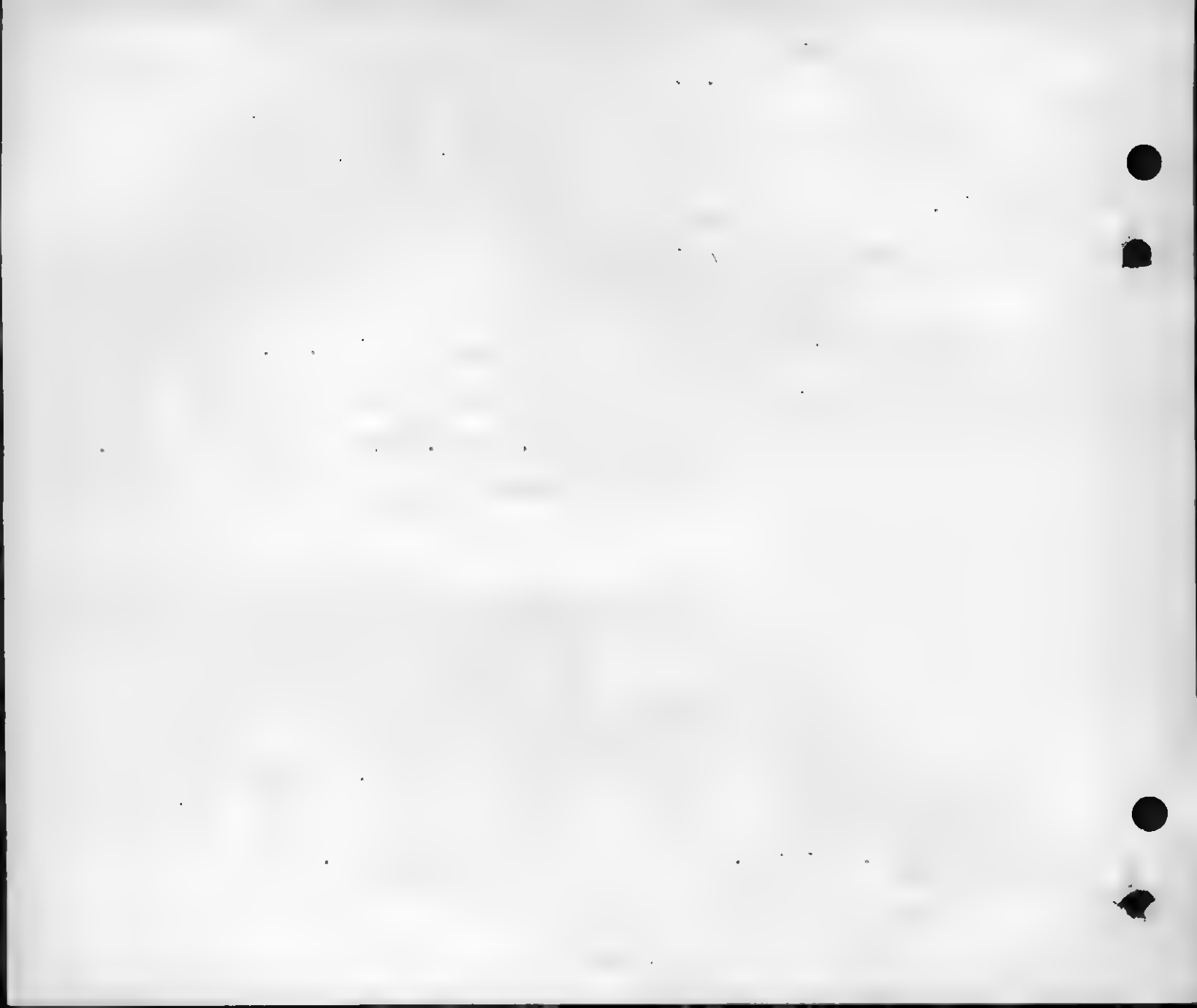
VR A15 (4)  
15M 9/59

13425  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13405

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena</b> c. LENGTH OF STAY IN 1b <b>1 1/2 day</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mrs. Bank's Care Home</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>3606 Ninth Street</b> d. STREET ADDRESS <b>Baltimore 25</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Daniel Howard Duffey</b>		4. DATE OF DEATH Month Day Year <b>December 24th, 1961</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/15/84</b>
9. AGE (In years last birthday) <b>77</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Anne Arundel Co. Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Duffey</b>		14. MOTHER'S MAIDEN NAME <b>Annette Johnson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-10-7256</b>	
17. INFORMANT <b>Mr. Elmer L. Duffey (son)</b>		Address <b>Glen Burnie, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic vascular diseases</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>No attendance</b> to <b>12/27/61</b> , that (I) (we) last saw the deceased alive on <b>12/27/61</b> , and that death occurred at <b>8 PM</b> from the causes and on the date stated above			
22a. SIGNATURE <b>Gustave H. Faubert, M.D.</b>		22b. ADDRESS <b>Glen Burnie, Md.</b>	
22c. PHYSICIAN'S NAME (Type) <b>Gustave H. Faubert, M.D.</b>		22d. ADDRESS <b>Glen Burnie, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 28, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Ritchie Hwy. 41 A. Co., Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>George J. Gonce</b>		25a. REC'D BY REGISTRAR <b>DEC 29 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>John L. Hume</b>		25c. DATE <b>DEC 29 '61</b>	

George J. Gonce

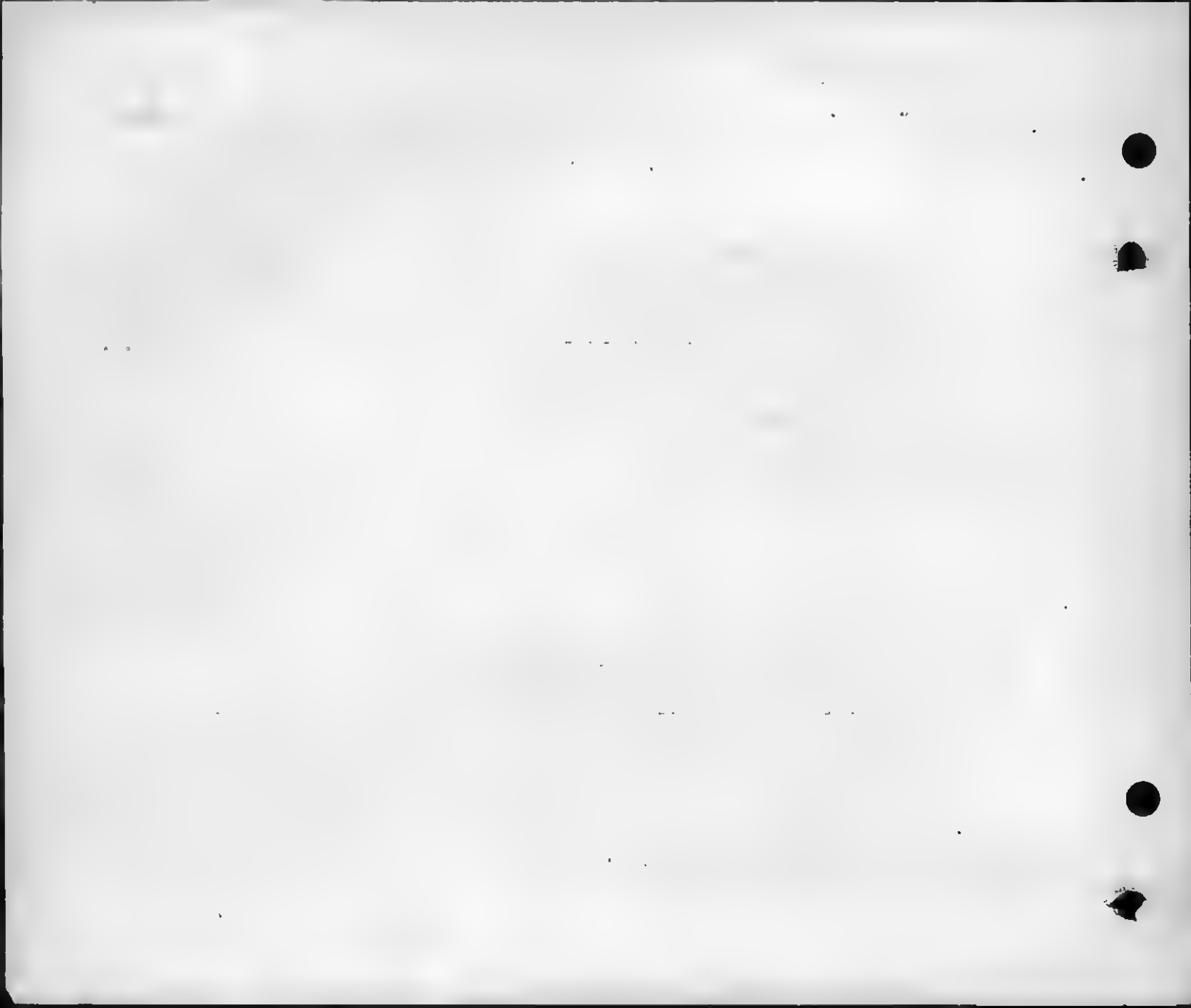


**CERTIFICATE OF DEATH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13426

13406

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY IN 1b <b>2 years</b> <b>3 mos. 4 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>1108 Pennsylvania Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Alice</b> Middle <b>Davis</b> Last <b>Edwards</b>		4. DATE OF DEATH Month <b>12</b> Day <b>8</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 1, 1888</b>
9. AGE (In years last birthday) <b>73</b>		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>15</b>	11. IF UNDER 24 HRS Hours <b>15</b> Min <b>00</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Anzi Davidson</b>		14. MOTHER'S MAIDEN NAME <b>Jane Carwell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> <b>7/5 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bed Sores</b> DUE TO (c) <b>Syphilitic Cardiovascular Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>43 X</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- 19 p. m. -----		20d. INJURY OCCURRED While ----- at work <input type="checkbox"/> or work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>		20f. (City or town) (County) (State) <b>-----</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>9/4/</b> 19 <b>59</b> to <b>12/8</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>12/8</b> 19 <b>61</b> , and that death occurred at <b>11:55 P.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Lionel McHenry Mapp, M. D.</b>		22b. DATE <b>12/11/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M. D.</b>		22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>12-24-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>21.07 M.D.</b>		23d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>William Luce, Jr. - Crownsville, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 29 1961</b>	
25b. REGISTRAR'S SIGNATURE <b>L. L. Luce</b>			



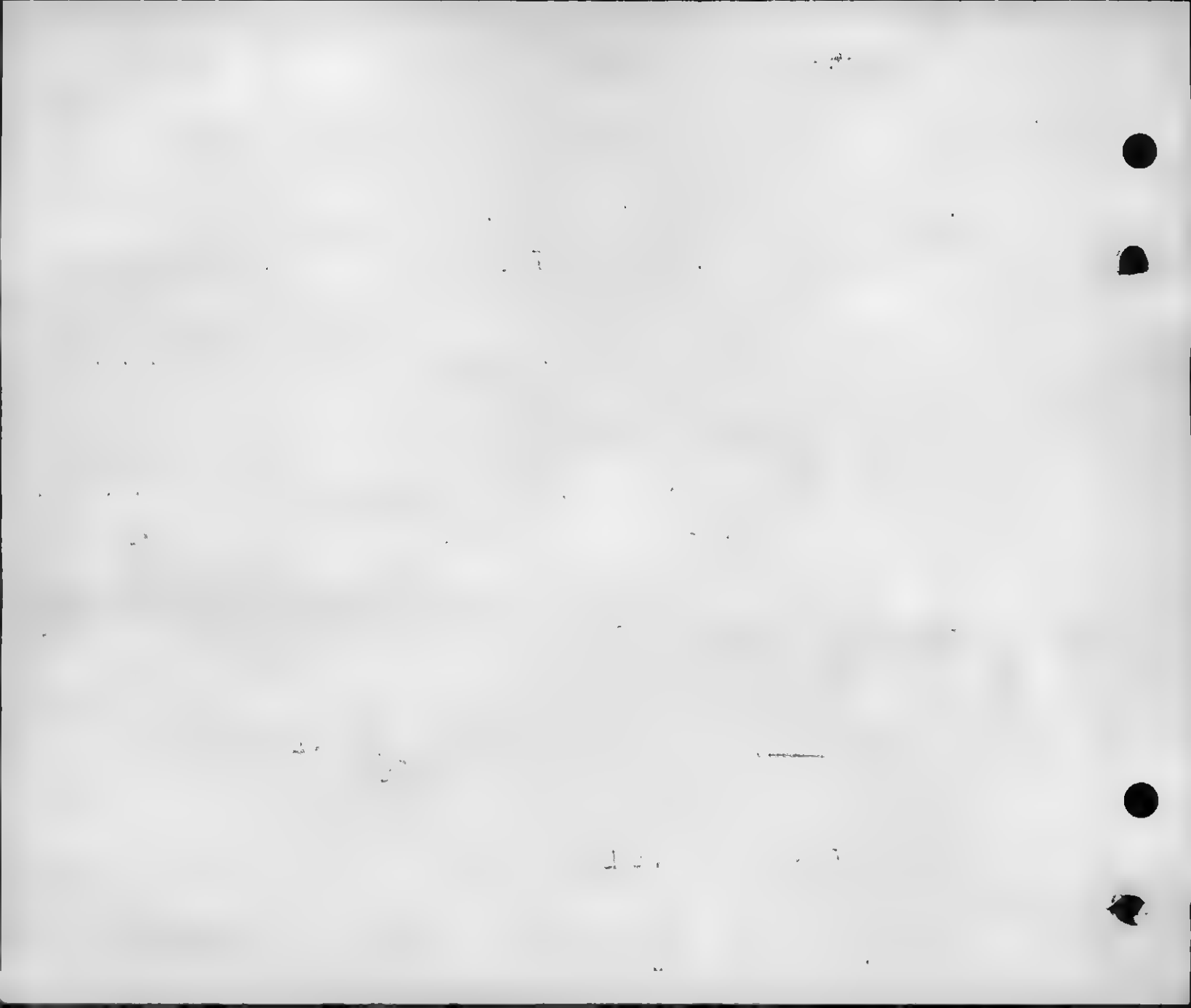
TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

13427 13407

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u> c. LENGTH OF STAY IN 1b <u>X</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rt. 2 Box 355 Alpine Beach</u> e. STREET ADDRESS <u>Rt. 2 Box 355 Alpine Beach</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u> d. STREET ADDRESS <u>Rt. 2 Box 355 Alpine Beach</u>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Lewis (Louis) F.</u>		<b>4. DATE OF DEATH</b> <u>December 27, 1961</u>	
<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>white</u>	
<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>June 11, 1895</u>		<b>9. AGE</b> (In years last birthday) <u>66 yrs.</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired Supervisor</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Mc Cormick Co.</u>	
<b>11. BIRTHPLACE</b> (Country & State, or foreign country) <u>Baltimore, Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Frederick Fickus</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Juniaunda Bayer</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>(If yes give year or dates of service)</u>		<b>16. SOCIAL SECURITY NO.</b> <u>212-01-0676</u>	
<b>17. INFORMANT</b> <u>Same</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarct</u> (b) <u>Arterio-sclerosis</u> (c) <u>Myocardial infarct 1958, very extensive</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>10 yrs.</u> (b) <u>1 1/2 hr.</u> (c) <u>10 yrs.</u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>	
<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of Item 18.)		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>19</u> p.m.	
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b>		<b>20g. (County)</b>	
<b>20h. (State)</b>		<b>21. I certify that (I) (the informant) attended the deceased from <u>October 1961</u> to <u>12/27</u>, 19<u>61</u>, that (I) <u>last</u> saw the deceased alive on <u>12/19</u>, 19<u>61</u>, and that death occurred at <u>1159</u> AM, from the causes and on the date stated above.</b>	
<b>22a. SIGNATURE</b> <u>C. Earl Hill</u>		<b>22b. DATE SIGNED</b> <u>DEC 29 '61</u>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>C. EARL HILL</u>		<b>22d. ADDRESS</b> <u>3708 Mountain Rd. Pasadena, Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>12/30/61</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Parwood Cemetery</u>		<b>23d. LOCATION (City, town or county)</b> <u>Baltimore, Maryland</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Leonard J. Kuck</u>		<b>25a. REC'D BY REGISTRAR</b> <u>DATE DEC 29 '61</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kline</u>		<b>25c. ADDRESS</b> <u>305 Hargord Road #14</u>	



1  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

13408

1. PLACE OF DEATH a. COUNTY <b>A.H.</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brooklyn</b> c. LENGTH OF STAY IN 1b <b>X</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>15 First Hos.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>A.H.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brooklyn</b> d. STREET ADDRESS <b>15 First Hos.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Elizabeth Finley</b> First Middle Last 4. DATE OF DEATH <b>12/19/61</b> Month Day Year		5. SEX <b>I</b> 6. COLOR OR RACE <b>W</b> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 7. DATE OF BIRTH <b>10/15/70</b> 8. AGE (In years last birthday) <b>91</b> yrs IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>None</b> 11. BIRTHPLACE (State or foreign country) <b>MD.</b> 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Chas. Schmidt</b> 14. MOTHER'S MAIDEN NAME <b>Joplin</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> 16. SOCIAL SECURITY NO. <b>143x</b> 17. INFORMANT <b>Family Name</b> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> 143x DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis, hypertension</b> DUE TO (c) <b>Diabetes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12/11</b> 19 <b>61</b> to <b>12/19</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>12/19</b> 19 <b>61</b> , and that death occurred at <b>12/19</b> 19 <b>61</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>John A. Schuchman</b> 22c. PHYSICIAN'S NAME (Type) <b>John A. Schuchman</b>		22b. DATE SIGNED M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>1217 S. Pine St. Baltimore</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>B</b> 23b. DATE THEREOF <b>12/23/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ATLANTIC</b> 23d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>1100 E. 130 E. 4000 Ave.</b> ADDRESS		25a. REC'D BY REGISTRAR <b>DEC 21 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Turner</b>	



## CERTIFICATE OF DEATH

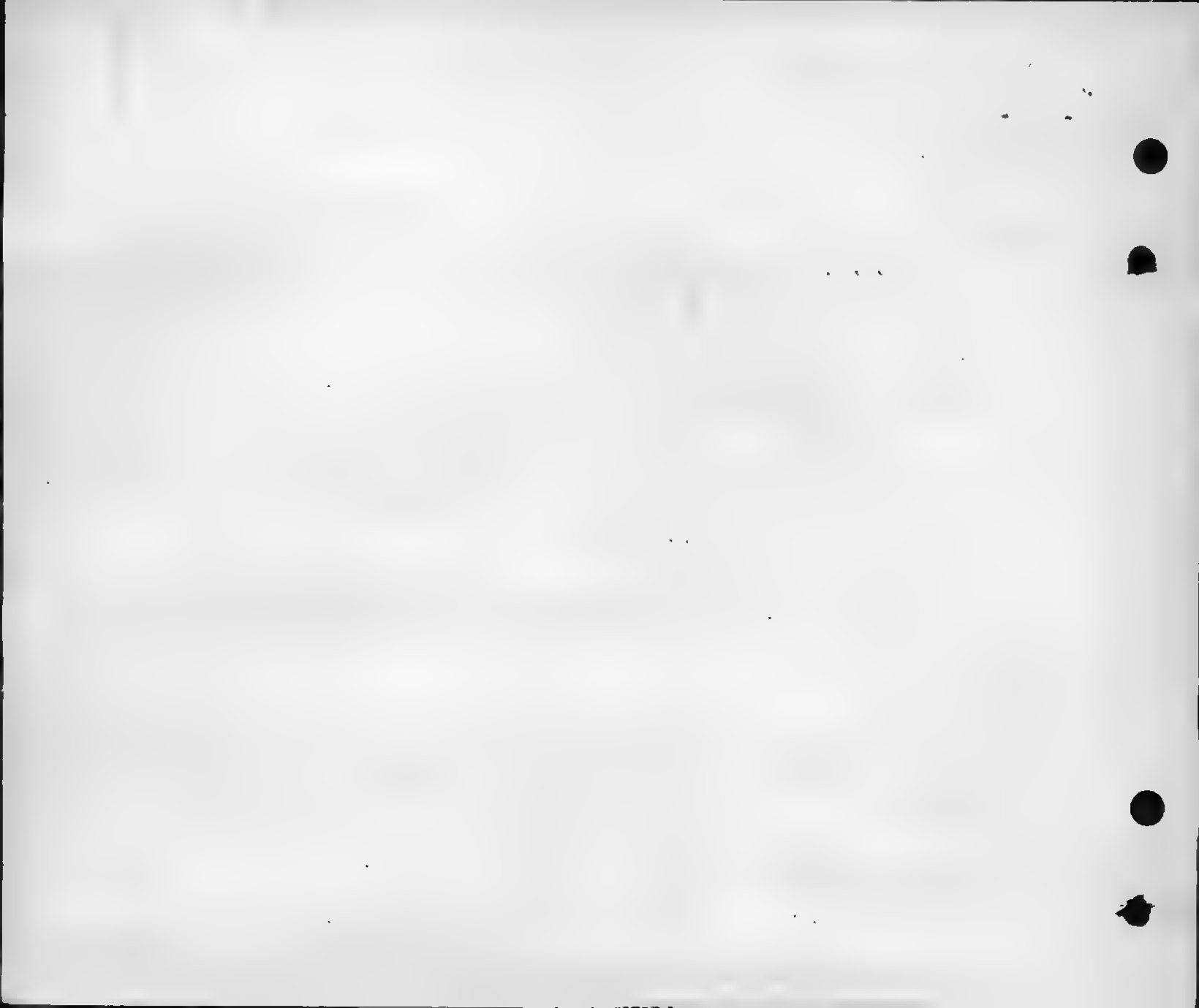
13409

Reg. Dist. No

13429

1. PLACE OF DEATH a. COUNTY <u>ANN ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>ANN ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FOOT, MD.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Glen Burnie</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ARMY HOSPITAL</u>		d. STREET ADDRESS <u>116 FURLEA DR.</u>	
3. NAME OF DECEASED (Type or print) <u>FLAHERTY, JOSEPH F</u>		4. DATE OF DEATH <u>12</u> Month <u>17</u> Day <u>19</u> Year <u>61</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>CAUC</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 1, 1885</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MASS.</u>	
11. BIRTHPLACE (State or foreign country) <u>MASS.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph FLAHERTY</u>		14. MOTHER'S MAIDEN NAME <u>MEANY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>MRS H POWELL, 116 FURLEA DR, GLEN BURNIE</u>	
17. INFORMANT <u>MRS H POWELL, 116 FURLEA DR, GLEN BURNIE</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>congestive heart disease</u> 720.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>hypertension</u> DUE TO (c) <u>poss. myocardial infarct (1947)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) <u>left sided parietal fracture</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>N/A</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>17 Dec</u> 19 <u>61</u> to <u>17 Dec</u> 19 <u>61</u> , that I last saw the deceased alive on <u>17 Dec</u> 19 <u>61</u> , and that death occurred at <u>14:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Herman I Rosenberg</u>		ADDRESS (Street, city or town, state) <u>KIM BROUGH ARMY HOSPITAL</u>	
PHYSICIAN'S NAME (Type) <u>HERMAN I ROSENBERG FT. GEORGE G. MEADE, MD</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12/20/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>	22d. LOCATION (City, town, or county) (State) <u>Akron Ohio</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard J. Hubbard</u>		ADDRESS <u>4107 Williams Ave</u>	
24a. REC'D BY REGISTRAR <u>DFG 19 61</u>		24b. REGISTRAR'S SIGNATURE <u>W. S. Finner</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 be retained in the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

14651

13430

1. PLACE OF DEATH a. COUNTY <b>A.A. CO.</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>4 mos - 15 days</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>MARY</b> b. COUNTY <b>2</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>720 Lexington</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CORA</b> Middle <b>91665</b> Last <b>91665</b>		4. DATE OF DEATH Month <b>12</b> Day <b>25</b> Year <b>1961</b>		5. SEX <b>F</b>		6. COLOR OR RACE <b>N</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1919</b>		9. AGE (in years last birthday) <b>42 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNKNOWN</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME <b>?</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT		Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia due to gangrenous bed sores.</b> DUE TO <b>sores.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>2. Old Subdural - Hematoma -</b> DUE TO <b>3. Multiple - fracture - Ribs - old.</b> (c) <b>12-25-61</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7-6-61</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fallen - fell on - was pushed out of 4th floor window</b>		20c. TIME OF INJURY Month, Day, Year <b>7-6-61</b> Hour <b>7:00</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Baltimore Md</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE <b>E. Linhardt</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>12/26/61</b>		EXAMINER'S NAME (Type) <b>E. Linhardt</b>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/3/62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hospital Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Crownsville Md</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles W. ...</b>		24a. REC'D BY REGISTRAR <b>JAN 11 '62</b>		24b. REGISTRAR'S SIGNATURE <b>John S. ...</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the funeral director. Give Pages 1, 2, and 3 to the funeral director. Give Page 4 to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 72 hours after the death. It should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL: Page 4 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

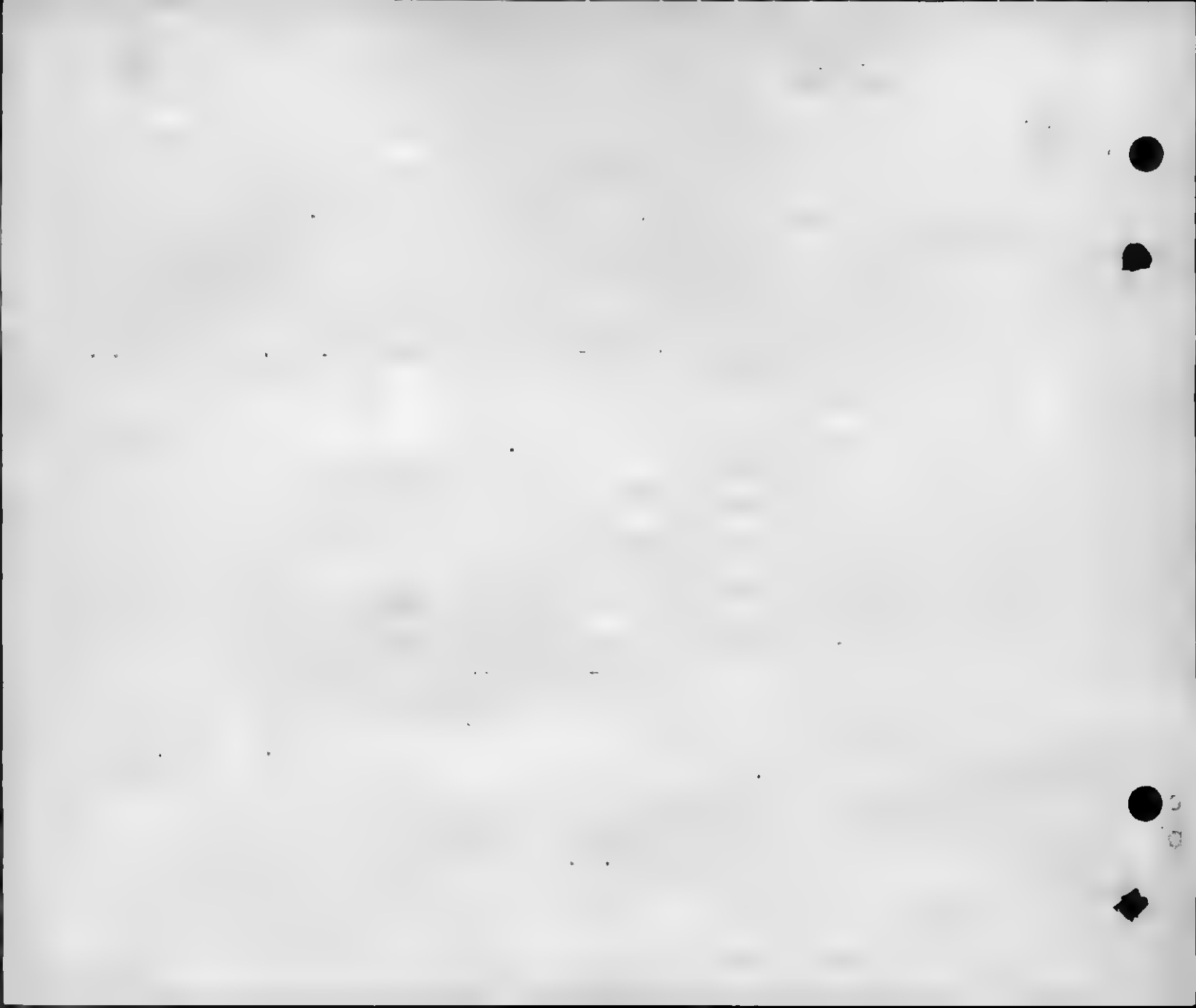
**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

13431

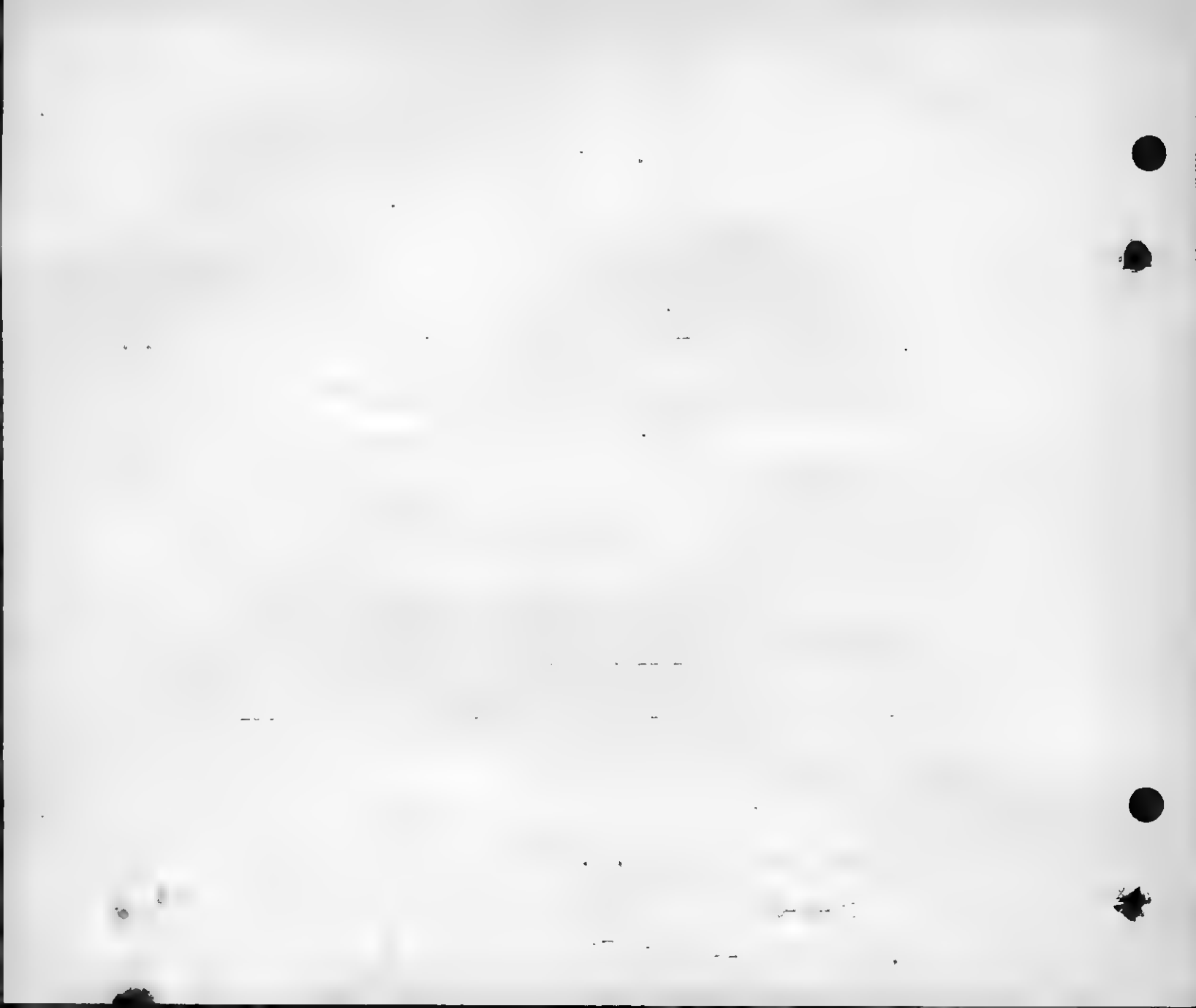
13410

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater</u> c. LENGTH OF STAY IN b <u>3 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>-----</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater</u> d. STREET ADDRESS <u>Muddy Creek Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Eva</u> Middle <u>Augusta</u> Last <u>Gross</u>		<b>4. DATE OF DEATH</b> Month <u>12</u> Day <u>14</u> Year <u>19 61</u>		<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>Negro</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>July 30, 1897</u> <b>9. AGE</b> (In years last birthday) <u>64</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> <b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>House-wife</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>-----</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Anne Arundel Co., Md.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>Thomas Sharps</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Louise Moulden</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>-----</u> <b>17. INFORMANT</b> <u>Mrs. Gladys Neal, Edgewater, Maryland</u> Address <u>-----</u>			
<b>18. CAUSE OF DEATH</b> (Enter on only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) <u>Hypertensive Cardiovascular Renal Disease</u> DUE TO (c) <u>Arteriosclerosis - Generalized</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Uremia, Hypostatic Pneumonia, Decubitus Ulcers</u>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>8 days</u> <u>15 years</u> <u>15 years</u> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II. of item 18.) <u>-----</u>		<b>20c. TIME OF INJURY</b> Month, Day, Year <u>March 19 59</u> Hour <u>  </u> m <u>  </u> p.m. <u>  </u>			
<b>20d. INJURY OCCURRED</b> While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>-----</u>		<b>20f. (City or town)</b> <u>Dec.</u> (County) <u>  </u> (State) <u>  </u>			
<b>21. I certify that (I) (this hospital) attended the deceased from... March 19 59 to Dec. 14, 19 61, that (I) (we) last saw the deceased alive on... Dec. 14, 19 61 and that death occurred at... 400 P.M., from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Lionel McHenry Mapp, M. D.</u> <b>22c. PHYSICIAN'S NAME</b> (Type) <u>Lionel McHenry Mapp, M. D.</u>		<b>22b. DATE SIGNED</b> <u>12/14/61</u> <b>22d. ADDRESS</b> <u>20 Dean Street, Annapolis, Maryland</u>		<b>22e. DATE SIGNED</b> <u>12/14/61</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> <u>Buried</u> <b>23b. DATE THEREOF</b> <u>Dec 17 1961</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Adams Chapel</u> <b>23d. LOCATION</b> (City, town or county) <u>Bayard Rd.</u> (State) <u>Mt. Zion Md</u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>T A Harkstey + Son</u> <b>25a. REC'D BY REGISTRAR</b> <u>DEC 21 1961</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kline</u>		<b>25c. NAME OF CEMETERY OR CREMATORY</b> <u>Galesville Md</u>			

MEDICAL CERTIFICATION







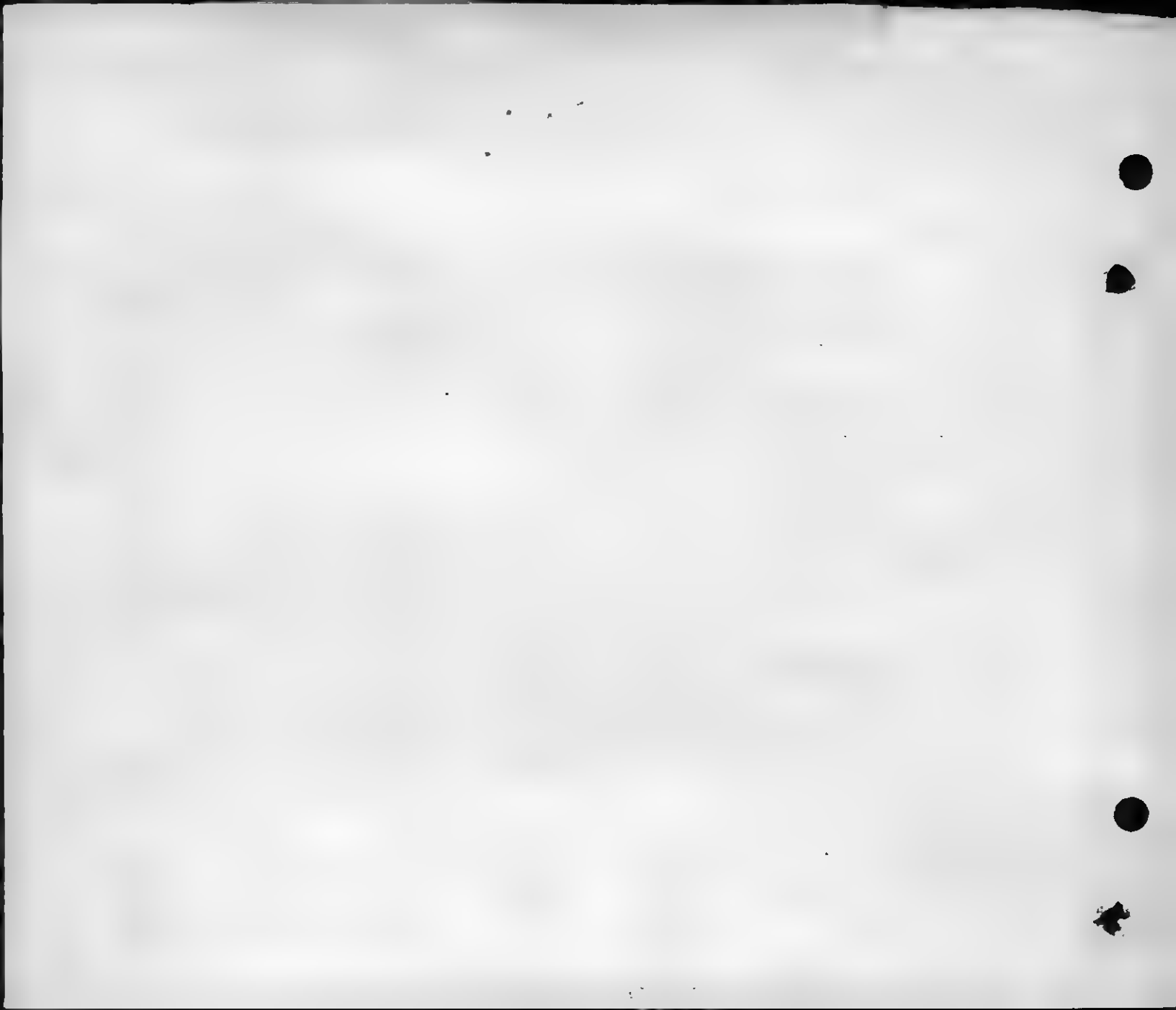
## CERTIFICATE OF DEATH

Reg. Dist. No. 13412

13433

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ft George G Meade</u>		c. LENGTH OF STAY IN 1b <u>Unk</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kimbrough Army Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Odenton</u>	
f. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kimbrough Army Hospital</u>		d. STREET ADDRESS <u>1617C Forrest Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Katherine</u> Last <u>Harrell</u>		4. DATE OF DEATH Month <u>December</u> Day <u>28</u> Year <u>19 61</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negroid</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>28 December 61</u>
9. AGE (In years lost birthday) yrs. <u>4</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>4</u> Days <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Silas Harrell Jr</u>		14. MOTHER'S MAIDEN NAME <u>Mary N. Graham</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mother</u>		Address <u>See item 2d</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs 15 Min</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>-</u>	
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>00</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u>	20f. (City or town) (County) (State) <u>-</u>
21. I certify that I attended the deceased from <u>28 December 19 61</u> , to <u>28 December 19 61</u> , that I last saw the deceased alive on <u>28 December 19 61</u> , and that death occurred at <u>1115 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Kimbrough Army Hospital Ft G G Meade, Md</u> DATE SIGNED <u>28 Dec 1961</u>			
ACTUAL SIGNATURE <u>Max W. Bloomberg</u> M.D. <u>Kimbrough Army Hospital Ft G G Meade, Md</u>			
PHYSICIAN'S NAME (Type) <u>MAX W. BLOOMBERG, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-2-62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Nat-Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Choy O. Wilson</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 5 '62</u>	24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: This form required that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

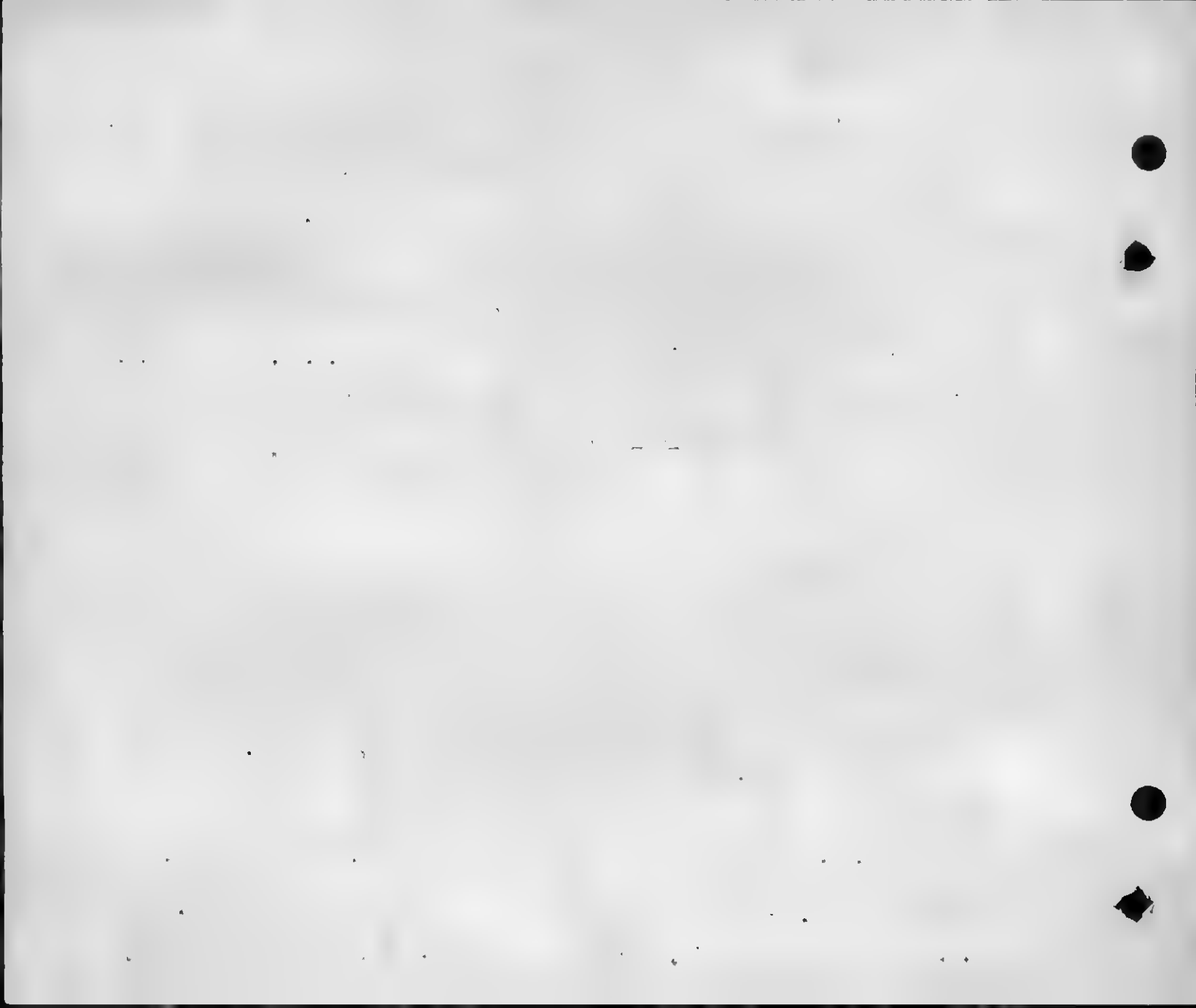
## CERTIFICATE OF DEATH

13434

13413

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN b. <u>10</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Anne Arundel</u></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> d. STREET ADDRESS <u>827 West St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Leon</u> First Middle Last <b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>Negro</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>B. DATE OF BIRTH</b> <u>HARRIS</u> <u>March 5, 1905</u> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		<b>9. AGE</b> (In years last birthday) <u>56</u> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min. <u>December 29, 1961</u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Taxi Cabs</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland A.A.Co.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>		<b>13. FATHER'S NAME</b> <u>William Harris</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Maggie Gallaway</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>578-16-2694</u> <b>17. INFORMANT</b> <u>Martha Tyler</u> Address <u>827 West St. Annapolis, Md.</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (e) <u>Pulmonary Embolus (Multiple)</u> <u>Arterio-sclerotic Hypertensive Cardin</u> <u>Varicose disease</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18) <b>20c. TIME OF INJURY</b> Month, Day, Year <u>Dec. 28, 1961</u> Hour a.m. p.m. <u>8:40 AM</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Dec</u> <b>20f. (City or town)</b> <u>Annapolis, Md.</u> <b>(County)</b> <u>Ann</u> <b>(State)</b> <u>Md</u>							
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Dec. 28, 1961</u> <b>to</b> <u>Dec. 28, 1961</u> <b>that (I) (we) last saw the deceased alive on</b> <u>Dec. 28, 1961</u> <b>and that death occurred at</b> <u>8:40 AM</u> <b>from the causes and on the date stated above.</b> <b>22a. SIGNATURE</b> <u>R. L. Richardson</u> <b>22b. DATE SIGNED</b> <u>Dec. 28, 1961</u> <b>22c. PHYSICIAN'S NAME (Type)</b> <u>R. L. Richardson</u> <b>22d. ADDRESS</b> <u>110 Clay St., Annapolis, Md.</u> <b>22e. ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>							
<b>23a. BURIAL, CREMATION REMOVAL (Specify)</b> <u>Burial</u> <b>23b. DATE THEREOF</b> <u>Jan. 1-62</u> <b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>C.E. Hicks III</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Brewer Hill</u> <b>23d. LOCATION (City, town or county)</b> <u>Annapolis, Md</u> <b>(State)</b> <u>Md</u> <b>25a. REC'D BY REGISTRAR</b> <u>Jan 5 '62</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Harris</u>					

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, the delay should be explained in the report. The report should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VS. A15ME  
SM 7/59

M

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MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>D.A. CO.</u> <u>MARYLAND</u>												2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montg.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Springs - MD</u> d. STREET ADDRESS <u>15 X 2</u>											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis - MD</u>												c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Springs - MD</u>											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>D.O.A. Anne Melwood General</u>												e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>Guy Tripp</u> <u>HEMPHILL</u>												DATE OF DEATH <u>12</u> <u>2</u> <u>1961</u>											
5. SEX <u>M</u>												6. COLOR OR RACE <u>W.</u>											
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>												8. DATE OF BIRTH <u>3-1-19</u>											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Executive States Marine Steamship Lines</u>												11. BIRTHPLACE (State or foreign country) <u>New York City</u>											
13. FATHER'S NAME <u>Clifford Hemphill</u>												14. MOTHER'S MAIDEN NAME <u>Mary G. Tripp</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>												16. SOCIAL SECURITY NO. <u>Julian Hemphill</u>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.4</u> <u>Claustrum</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Claustrum</u> (a), stating the underlying cause last. DUE TO (c) <u>Claustrum</u>												12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>											
PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year <u>19</u>												20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)												20f. (City or town) (County) (State)											
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
ACTUAL SIGNATURE <u>C. Hemphill</u>												M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
EXAMINER'S NAME (Type) <u>E. Linhardt</u>												DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
Address (Street, city, town, or county) <u>12-2-61</u>												DATE SIGNED											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>												22b. DATE THEREOF <u>Dec 5<sup>th</sup> 1961</u>											
22c. NAME OF CEMETERY OR CREMATORY <u>Hollercrest Memorial</u>												22d. LOCATION (City, town, or country) (State) <u>Annapolis</u> <u>MD</u>											
23. FUNERAL DIRECTOR <u>John M. Saylor Sons</u>												24a. REC'D BY REGISTRAR <u>DEC 6 '61</u>											
ADDRESS <u>Annapolis Md</u>												24b. REGISTRAR'S SIGNATURE <u>John S. Saylor</u>											



13437

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13417

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SEVERNA PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SEVERNA PARK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RT 2 Box 547</u>		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>DAISY</u> Middle <u>KLEIN</u> Last <u>HUMPLE</u>		4. DATE OF DEATH Month <u>12</u> Day <u>11</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-8-1869</u>
9. AGE (In years last birthday) <u>92</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	11. IF UNDER 24 HRS Hours <u>  </u> Min <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>SAMUEL AYERS</u>		14. MOTHER'S MAIDEN NAME <u>KATRIKA COOPER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>  </u>	
17. INFORMANT <u>FAMILY</u>		Address <u>ABOVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1955</u> , 19 <u>  </u> , to <u>1961</u> , 19 <u>  </u> . That (I) (we) last saw the deceased alive on <u>12-10-1961</u> , and that death occurred at <u>5:30</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert R. Hahn</u>		22b. DATE SIGNED <u>12-11-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT R. HAHN</u>		22d. ADDRESS <u>RITCHIE HWY - SEVERNA PARK</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12-13-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>BALTO. CEM.</u>		23d. LOCATION (City, town, or county) (State) <u>BALTO, MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Baranov</u>		25. REC'D BY REGISTRAR <u>DEC 14 '61</u>	
25a. ADDRESS <u>Severna Park, Md</u>		25b. REGISTRAR'S SIGNATURE <u>Richard J. Hahn</u>	

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TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours after death. If the deceased was retained in the hospital or attending physician, the certificate should be signed by the attending physician and completely filled in by the funeral director. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 48 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
13438											
13418											
1. PLACE OF DEATH a. COUNTY <u>Anne Arundle</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>11</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Patapsco Park</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>					
c. LENGTH OF STAY IN 1b						d. STREET ADDRESS <u>6034 Bellegrove Rd.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6034 Bellegrove Rd.</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>ANNIE LEE JOHNSON</u>						4. DATE OF DEATH <u>Dec 7 - 1961</u>					
5. SEX <u>Female</u>						6. COLOR OR RACE <u>Negro</u>					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>						8. DATE OF BIRTH <u>June - 19 - 1904</u>					
9. AGE (In years last birthday) <u>57</u> yrs.						10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>					
10b. KIND OF BUSINESS OR INDUSTRY						11. BIRTHPLACE (County & State, or foreign country) <u>Suffolk Va.</u>					
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>						13. FATHER'S NAME <u>Ed. White-Willie</u>					
14. MOTHER'S MAIDEN NAME <u>Mary L. Lawrence</u>						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)					
16. SOCIAL SECURITY NO						17. INFORMANT <u>Annette J. Hankins</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>AC CEREBRAL HEMORRHAGE</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> (c) <u>DUE TO</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>3/4/1958</u> to <u>12/7/1961</u> , that (I) (we) last saw the deceased alive on <u>10/10/1961</u> , and that death occurred at <u>AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>John B. ...</u>						22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <u>JOHN STRAXTON JR.</u>						22d. ADDRESS <u>1725 ...</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						23b. DATE THEREOF <u>12-11-61</u>					
23c. NAME OF CEMETERY OR CREMATORY <u>MT Auburn Cem</u>						23d. LOCATION (City, town or county) (State) <u>Baltimore Md</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Chas O. Wilson</u>						25a. REC'D BY REGISTRAR <u>1008 ...</u>					
25b. REGISTRAR'S SIGNATURE <u>...</u>						DATE <u>DEC 13 '61</u>					



MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13439

12/19/61 iwk

13419

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MARLEY</b> c. LENGTH OF STAY IN 1b <b>NO</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Box 95 Spencer Rd</b>		2. USUAL RESIDENCE (Where deceased lived) If institution. Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>ANNE ARUNDEL</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>NO MARLEY</b> d. STREET ADDRESS <b>Box 95 Spencer Rd</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES HENRY JOHNSON</b>		4. DATE OF DEATH Month Day Year <b>12 12 1961</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/8/1885</b>
9. AGE (In years last birthday) <b>76</b>		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>	
11. BIRTHPLACE (State or foreign country) <b>A.A. Co MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HENRY JOHNSON</b>		14. MOTHER'S MAIDEN NAME <b>REBECCA unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>REBECCA JOHNSON - MARLEY MD</b>	
17. INFORMANT Address <b>REBECCA JOHNSON - MARLEY MD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 442 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Cardiovascular Disease</b> DUE TO (c) <b>Unknown</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Several Hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>11-27-1961</b> to <b>12-12-1961</b> , that (I) (we) last saw the deceased alive on <b>12-11-1961</b> , and that death occurred <b>12-12-1961</b> M, from the causes and on the date stated above			
22a. SIGNATURE <b>Richard H. Hunt</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>RICHARD H. HUNT</b>		22d. ADDRESS <b>100 Cherry Lane, Glen Burnie, Md</b>	
23a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12/19/1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hales R.F. Church</b>	23d. LOCATION (City, town, or county) (State) <b>Sally - A.A. Co. Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Marshall Atkins 638 N. Gilmor St</b>		25a. REC'D BY REGISTRAR <b>DEC 14 '61</b>	
ADDRESS <b>BALTO-17-MD</b>		25b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

Dear Sir,  
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the above named matter.  
I am sorry to hear that you are not satisfied with the result of the investigation.  
I have been very busy lately, and have not had time to devote to this matter as much as I would wish.  
I am, Sir, very respectfully,  
Yours,  
J. H. [Name]

1881

Very truly,  
Yours,  
J. H. [Name]

TO HOSPITAL  
The law requires that the health certificate be executed within 72 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

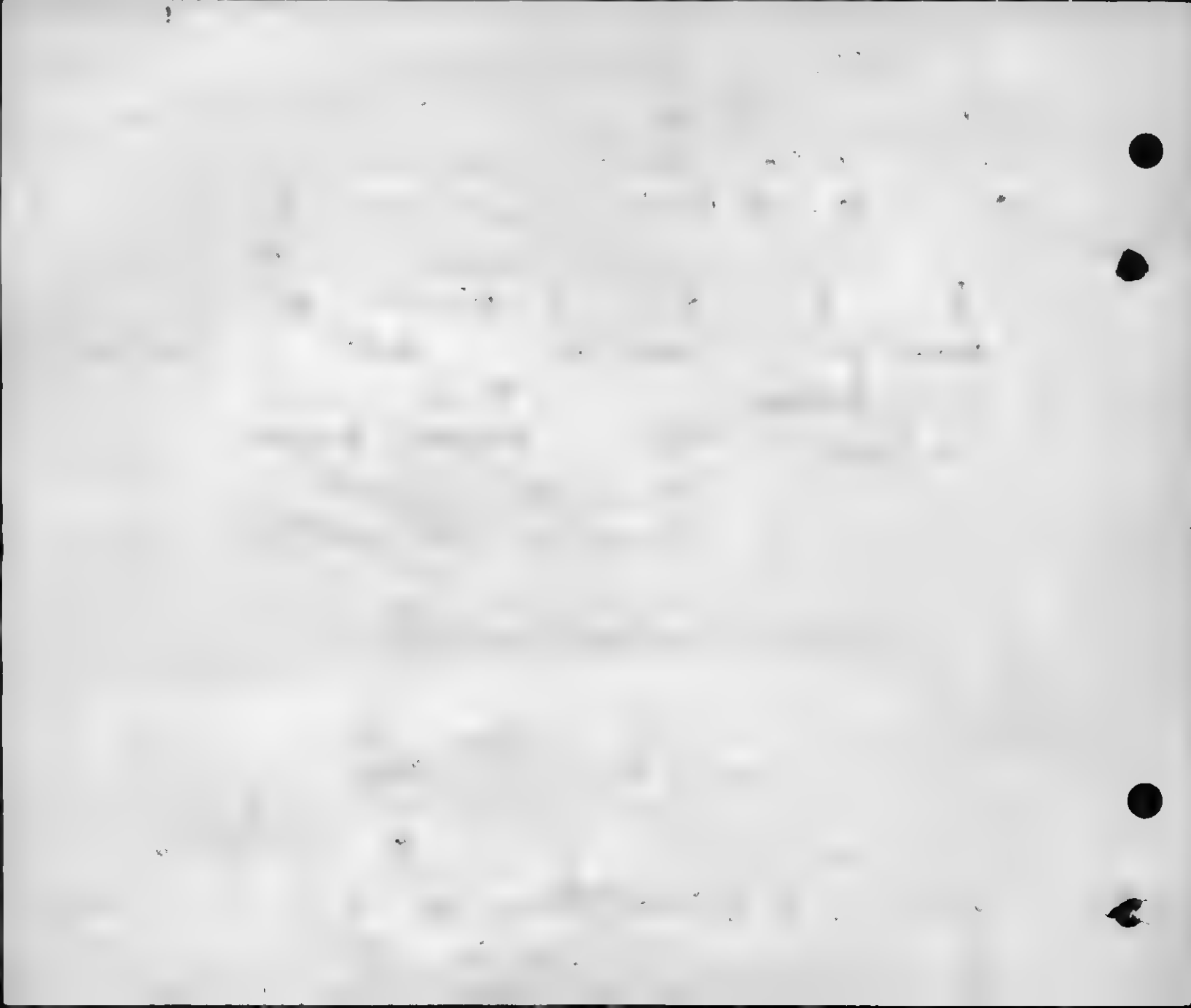
13440

**CERTIFICATE OF DEATH**

Item 14 File G304 1/2/62 ink

13420

<b>1. PLACE OF DEATH</b> a. COUNTY <i>Crownsville</i> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Crownsville, Md</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Crownsville State Hospital</i> e. STREET ADDRESS <i>25 S. Bernice Ave</i>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Balto</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> d. STREET ADDRESS <i>25 S. Bernice Ave</i>		<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <i>Willie Eugene Jones</i>		<b>4. DATE OF DEATH</b> Month Day Year <i>Dec 16 1961</i>													
<b>5. SEX</b> <i>F</i>		<b>6. COLOR OR RACE</b> <i>N</i>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <i>unknown</i>		<b>9. AGE</b> (In years less birthday) <i>63</i> yrs.		<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>11. IF UNDER 24 HRS.</b> Months Days Hours Min.							
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>unknown</i>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <i>U.S.A.</i>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>USA</i>		<b>13. FATHER'S NAME</b> <i>Willie Eugene</i>		<b>14. MOTHER'S MAIDEN NAME</b> <i>Frances unknown</i>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give number of service) <i>unknown</i>		<b>16. SOCIAL SECURITY NO.</b> <i>unknown</i>		<b>17. INFORMANT</b> Address <i>Hospital Records</i>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a). <i>Enlarged atherosclerosis</i> <i>Hypertension - Serial Dissection</i>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <i>1 day</i>		<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.)		<b>20c. TIME OF INJURY</b> Hour a.m. p.m. <i>19</i>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. CITY OR TOWN</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from...</b> <i>7/15</i> <b>19</b> <i>61</i> <b>to</b> <b>19</b> <i>61</i> <b>that (I) (we) last saw the deceased alive on...</b> <i>12/16</i> <b>19</b> <i>61</i> <b>and that death occurred at...</b> <i>12/16</i> <b>19</b> <i>61</i> <b>from the causes and on the date stated above.</b>		<b>22a. SIGNATURE</b> <i>Dr. L. Whit</i>		<b>22b. PHYSICIAN'S NAME</b> (Type) <i>Dr. L. Whit</i>		<b>22c. ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>		<b>22d. ADDRESS</b> <i>Crownsville, Md</i>		<b>22e. DATE SIGNED</b> <i>12/17/61</i>		<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <i>Burial</i>		<b>23b. DATE THEREOF</b> <i>12-20-61</i>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <i>St. Calvary Cem</i>		<b>23d. LOCATION</b> (City, town or county) (State) <i>A.A. Co Md</i>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Rayner Sanders</i>		<b>24a. ADDRESS</b> <i>217 E. Preston St</i>		<b>25a. REC'D BY REGISTRAR</b> <i>DEC 22 '61</i>		<b>25b. REGISTRAR'S SIGNATURE</b> <i>Wm. S. Peters</i>		<b>25c. DATE</b>		<b>25d. SIGNATURE</b>		<b>25e. DATE</b>		<b>25f. SIGNATURE</b>		<b>25g. DATE</b>			



13421

1	PLACE OF DEATH	a. COUNTY	Anne Arundel	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission)	a. STATE	Maryland	b. COUNTY	Anne Arundel
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN TB	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3	NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
5	SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> ? DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday) yrs	IF UNDER 1 YEAR	IF UNDER 24 HRS		
10a.	USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?					
13.	FATHER'S NAME	14. MOTHER'S MAIDEN NAME	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address			
18.	CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a.	ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	20c. TIME OF INJURY	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21	I certify that (I) (this hospital) attended the deceased from 5/28 1957 to 12/28 1961, that (I) (we) last saw the deceased alive on 12/28 1961, and that death occurred on 12/28 1961 from the causes and on the date stated above.	22a. SIGNATURE	22b. DATE SIGNED	22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE		
23a.	BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county)	(State)	25c. REC'D BY REGISTRAR	25d. REGISTRAR'S SIGNATURE		



may be retained in hospital or attending physician. TO GENERAL DIRECTOR: If this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13442

CERTIFICATE OF DEATH

Reg. Dist. No. 13422

1. PLACE OF DEATH a. COUNTY <u>Lothian, A.A. Co</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Lothian Md.</u> b. COUNTY <u>A.A. Co. Md.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LOTHIAN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LOTHIAN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>FOLLING HOUSE RD.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle <u>MAY</u> Last <u>WIER</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>8</u> Year <u>19 61</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 23, 1872</u>
9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>A.A. Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Joseph Wier</u>		14. MOTHER'S MAIDEN NAME <u>Sallie Wood</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>  </u>	
17. INFORMANT <u>Nellie Jones</u>		Address <u>Lothian, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Disease</u> DUE TO <u>  </u> (c) <u>Hypertension</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July</u> , 19 <u>56</u> , to <u>Dec. 8</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Dec. 8</u> , 19 <u>61</u> , and that death occurred at <u>4:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>  </u> DATE SIGNED <u>  </u>			
ACTUAL SIGNATURE <u>Emily H. Wilson</u> M.D.		PHYSICIAN'S NAME (Type) <u>Emily H. Wilson M.D.</u> <u>Lothian</u> <u>Anne Arundel</u> <u>Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12-11-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT. ZION</u>	22d. LOCATION (City, town, or county) (State) <u>MT. ZION</u> <u>MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor &amp; Sons Annapolis, Md.</u>		24. REC'D BY REGISTRAR DATE <u>Dec 13 1961</u>	
24b. REGISTRAR'S SIGNATURE <u>  </u>		24c. REGISTRAR'S SIGNATURE <u>  </u>	

MEDICAL CERTIFICATION

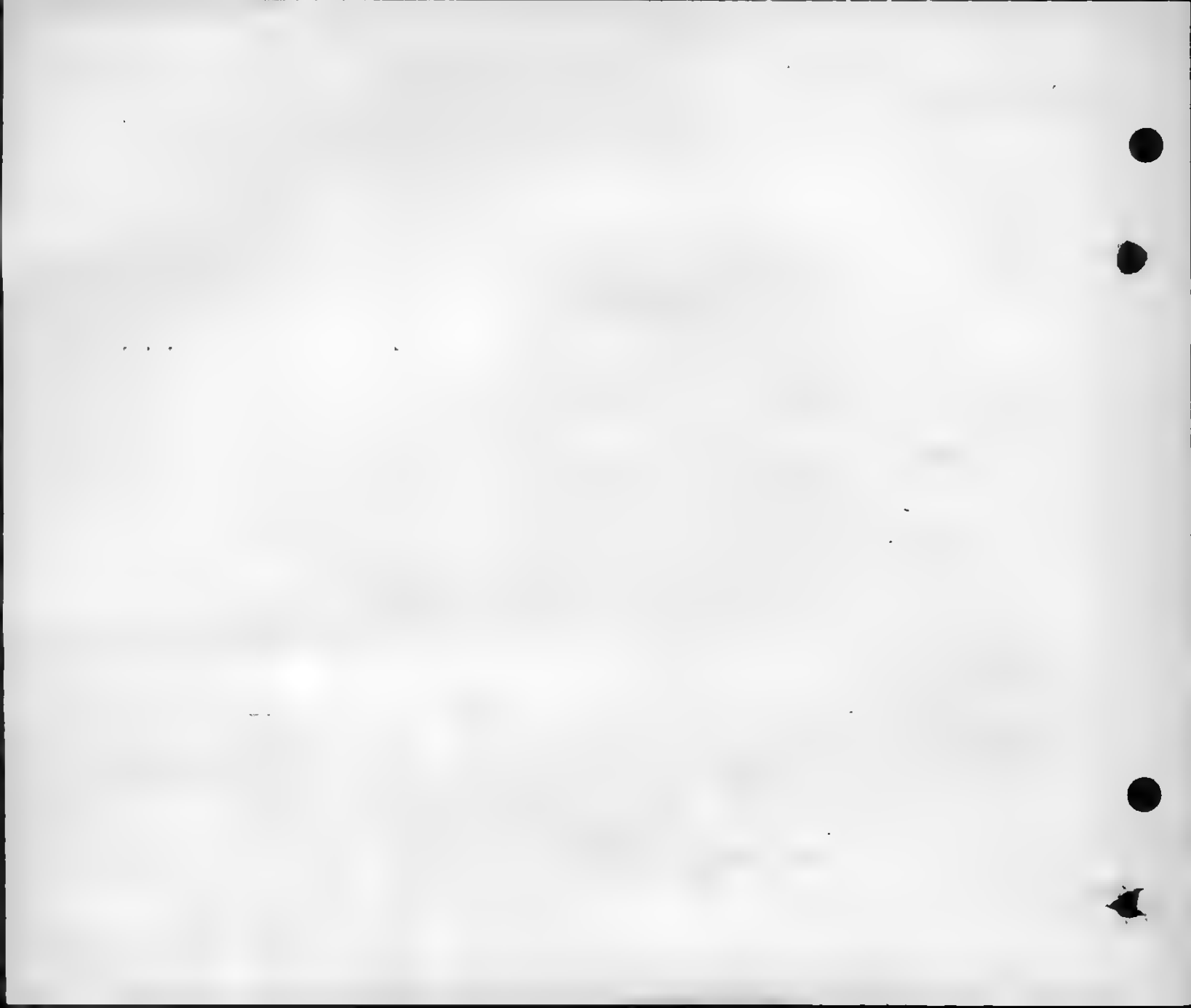


TO HOSPITAL OR A NURSING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the deceased was retained in a hospital or attending physician, this certificate should be signed by the attending physician and completely filled in by the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
TSM 9/59

1  
13443  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
13423

1 PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY IN 1b <b>26 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>923 Leadenhall Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Russell</b> Middle <b>Jones</b> Last <b>Jones</b>		4. DATE OF DEATH Month <b>12</b> Day <b>19</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 3, 1900</b>
9 AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months <b>12</b> Days <b>19</b> Hours <b>16</b> Min <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (State or foreign country) <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Jones</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>Pulmonary Tuberculosis - Active &amp; Bilateral</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>-----</b> DUE TO (c) <b>-----</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome Associated with Cerebral Arteriosclerosis</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>	
20c. TIME OF INJURY Month, Day, Year Hour a m <b>-----</b> 19 p. m <b>1</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>		20f. (City or town) <b>-----</b> (County) <b>-----</b> (State) <b>-----</b>	
21 I certify that (I) (this hospital) attended the deceased from <b>11/23</b> 19 <b>61</b> to <b>12/19</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>12/19</b> 19 <b>61</b> , and that death occurred at <b>7:58 A.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Lionel McHenry Mapp, M. D.</b>		22b. DATE <b>12/20/61</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>12/23/61</b>		23b. DATE THEREOF <b>12/23/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Int. Auburn</b>		23d. LOCATION (City, town, or county) <b>Bethesda</b> (State) <b>Ind.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joe S. Nelson</b>		25a. REC'D BY REGISTRAR <b>DEC 21 '61</b>	
ADDRESS <b>1348 N. Calhoun St.</b>		25b. REGISTRAR'S SIGNATURE <b>W. S. Thacker</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the deceased was retained in a hospital or attending physician, this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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ISM 9/59

Page 4

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13444

13424

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>9 yrs. 3 days</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Somerset</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		e. STREET ADDRESS <b>Paper Street</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Stanley</b>		Middle <b>Jones</b>		Last <b>Jones</b>		4. DATE OF DEATH Month <b>12</b>		Day <b>21</b>		Year <b>19 61</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1877</b>		9. AGE (In years lost birthday) <b>84</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Hospital Records</b>		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> 471 / DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) DUE TO										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus - Arteriosclerotic Cardiovascular Disease - Deficiency Mental</b>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>		20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- 19 p. m. -----		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12/18</b> 19 <b>61</b> to <b>12/21</b> 19 <b>61</b> that (I) (we) lost saw the deceased alive on <b>12/21</b> 19 <b>61</b> , and that death occurred on <b>12/21</b> 19 <b>61</b> at <b>6:55</b> a. M., from the causes and on the date stated above										22b. DATE <b>12/21/61</b>	
22a. SIGNATURE <i>Hilda Reissmann</i>		22c. PHYSICIAN'S NAME (Type) <b>Dr. Hilda Reissmann</b>		22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>		22e. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>12/21/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's</b>		23d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <i>William Bede</i>		24b. ADDRESS <i>Anna, Md.</i>		25a. REC'D BY REGISTRAR <b>DEC 29 '61</b>		25b. REGISTRAR'S SIGNATURE <i>William E. Hanna</i>					



1  
FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12445 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13425

Items 11, 13, 14 fill in 6303 12/27/61 mh

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>		c. LENGTH OF STAY IN 1b <b>MARYLAND</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>ANNE ARUNDEL GENERAL HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>	
3. NAME OF DECEASED (Type or print) <b>VIRGINIA</b>		Last <b>LEE Jones</b>		DATE OF DEATH <b>12 17 19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-1-61</b>	9. AGE (In years last birthday) <b>2 1/2</b>	IF UNDER 1 YEAR Months <b>2 1/2</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Calv. Co., Md.</b>	
13. FATHER'S NAME <b>Melvin Jones</b>		14. MOTHER'S MAIDEN NAME <b>Ruth Creek</b>		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give number or dates of service)		17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>391.2 Otitis Media</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Russell S. Fisher</b>		M.D.		DATE SIGNED <b>12-17-61</b>	
EXAMINER'S NAME (Type) <b>RUSSELL S. FISHER, M.D.</b>		Address (Street, city, town, or county)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12-19-61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Union Chapel Cem.</b>	22d. LOCATION (City, town, or county) <b>Mt. Kender</b>	23. FUNERAL DIRECTOR <b>Leroy E. Berry - Huntingtown, Md.</b>	
24a. REC'D BY REG. STRAR <b>DEC 21 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kins</b>			



Page 4  
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained in the hospital or attending physician's office for 10 days after death. It must be returned to the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/59

1  
 2  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

13446

13426

1. PLACE OF DEATH a. COUNTY <u>A. A.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b <u>1208</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. A. General</u>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>aa</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> d. STREET ADDRESS <u>1208 Brushers St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>F.</u> Last <u>Heckler</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>1st</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 10 - 1923</u>
9. AGE (In years last birthday) <u>39</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S.N.A. Power Plant</u>	
11. BIRTHPLACE (State or foreign country) <u>Phila Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Harry Heckler</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW II - Korean</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mrs Daisy M. Heckler</u> Address <u>(2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 HOUR</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1 Jan. 1959</u> to <u>1 Dec. 1961</u> , that (I) (we) last saw the deceased alive on <u>27 Nov. 1961</u> , and that death occurred at <u>5 P.M.</u> , from the causes and on the date stated above			
22a. SIGNATURE <u>Edward Beck</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-5-1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Memorial</u>		23d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sns</u> ADDRESS <u>Annapolis Md</u>		25a. RECEIVED BY REGISTRAR <u>DEC 6 1961</u> DATE	
		25b. REGISTRAR'S SIGNATURE <u>J. S. Thomas</u>	



TO HOSPITAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL DIRECTOR: The law requires that the death certificate be filed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO HOSPITAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

13447

13427

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Anne Arundel General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>10 Annapolis</b> d. STREET ADDRESS <b>15 Bay Ridge Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Rachael</b> First Middle Last <b>SURGEON KENT</b>		4. DATE OF DEATH Month Day Year <b>December 24 1961</b>	
5. SEX <b>Female</b> 6. COLOR OR RACE <b>Negro</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 10, 1896</b> 9. AGE (In years last birthday) <b>65 yrs.</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b> 11. BIRTHPLACE (County & State, or foreign country) <b>U. S. A.</b> 12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>RICHARDSON GRAYSON</b> 14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b> 16. SOCIAL SECURITY NO <b>UNKNOWN</b> 17. INFORMANT <b>LOUISE WISE - 107 LARUE SQUARE - BALT MD.</b> Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> <b>450</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Congestive Heart Failure</b> (c) <b>Generalized Arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <b>10 yrs.</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 23, 1961</b> , to <b>Dec. 24, 1961</b> , that (I) (we) last saw the deceased alive on <b>Dec. 24, 1961</b> , and that death occurred at <b>4 PM</b> , from the causes and on the date stated above.		22a. SIGNATURE <b>Theodore H. Johnson</b> 22b. DATE SIGNED <b>12/28/61</b> 22c. PHYSICIAN'S NAME (Type) <b>Theodore H. Johnson, M. D.</b> 22d. ADDRESS <b>37 Calvert St., Annapolis, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b> 23b. DATE THEREOF <b>12-28-61</b> 23c. NAME OF CEMETERY OR CREMATORY <b>ANNAPOLIS Neck</b> 23d. LOCATION (City, town or county) (State) <b>ANNAPOLIS - Md.</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>C. E. Hicks</b> 25. REC'D BY REGISTRAR <b>JAN 5 '62</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hester</b>	



Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The attending physician or attending physician at the hospital or attending physician at the funeral home should sign this certificate. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
13448  
CERTIFICATE OF DEATH  
13428

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort George G Meade</b> c. LENGTH OF STAY IN lb <b>Unk</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kimbrough Army Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Odenton</b> d. STREET ADDRESS <b>1221 Rita Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Louie</b> Last <b>Kiser</b>		4. DATE OF DEATH Month <b>December</b> Day <b>28</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6 May 1924</b>
9. AGE (In years lost birthday) <b>37 yrs</b>		10. IF UNDER 1 YEAR Months <b>3</b> Days <b>10</b> Hours <b>10</b> Min.	11. IF UNDER 24 HRS Months <b>3</b> Days <b>10</b> Hours <b>10</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Soldier</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>US Army</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Grover Clevelan Kiser</b>		14. MOTHER'S MAIDEN NAME <b>Deceased</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give year or dates of service) <b>July 1944 to date</b>		16. SOCIAL SECURITY NO. <b>245-18-0834</b>	
17. INFORMANT <b>Personnel Records US Army Ft Geo G Meade, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>Acute pancreatitis</b> IMMEDIATE CAUSE (a) <b>28 7.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>28 Dec 1961</b> to <b>28 Dec 1961</b> , that (I) <b>was</b> lost saw the deceased alive on <b>28 Dec 1961</b> , and that death occurred at <b>0538</b> A. M., from the causes and on the date stated above.			
22a. SIGNATURE <b>Therma H. Roberts</b>		22b. DATE SIGNED <b>28 December 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>S. L. S. 30 ST'S, CAPT, MC</b>		22d. ADDRESS <b>Kimbrough Army Hospital Ft Geo G Meade, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE/THEREOF	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE		25a. REC'D BY REGISTRAR <b>DATE JAN 3 '62</b>	
ADDRESS		25b. REGISTRAR'S SIGNATURE	



TO HOSPITAL: ATTENDING PHYSICIAN: This form requires that the death certificate be evaluated within 24 hours after death. Page 4 must be retained by the hospital or attending physician. The FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

13449

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13429

1. PLACE OF DEATH

a. COUNTY

Anne Arundel

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Annapolis

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Anne Arundel General Hospital

3. NAME OF

(Type or print)

Owen

Middle

Last

Layton

4. DATE OF DEATH

Month

Day

Year

December

29

1961

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

7-15-81

9. AGE (In years last birthday)

79 80 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Foreman

10b. KIND OF BUSINESS OR INDUSTRY

Holmes Bakery

11. BIRTHPLACE (County & State, or foreign country)

New York

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

John O. Layton

14. MOTHER'S MAIDEN NAME

Rose Gates

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)

16. SOCIAL SECURITY NO.

578-09-6606

17. INFORMANT

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour a.m.

p.m.

19

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

While at work ☐ Not While at work ☐

20f. [City or town]

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Oct 1961, to 12/29/61, 19....., that (I) saw the deceased alive on 12/29/61, 19....., and that death occurred 4 P.M., from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

Dr. Willard Smith

M.D.

ATTENDING PHYS.

MED. DIRECTOR ☐

STAFF PHYS. ☐

22d. ADDRESS

Shadyside, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

1-2-62

23c. NAME OF CEMETERY OR CREMATORY

Cedar Hill

23d. LOCATION (City, town or county)

Suitland

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Washington D.C.

25a. REC'D BY REGISTRAR

JAN 5 1962

25b. REGISTRAR'S SIGNATURE

William L. Thomas

INTERVAL BETWEEN ONSET AND DEATH

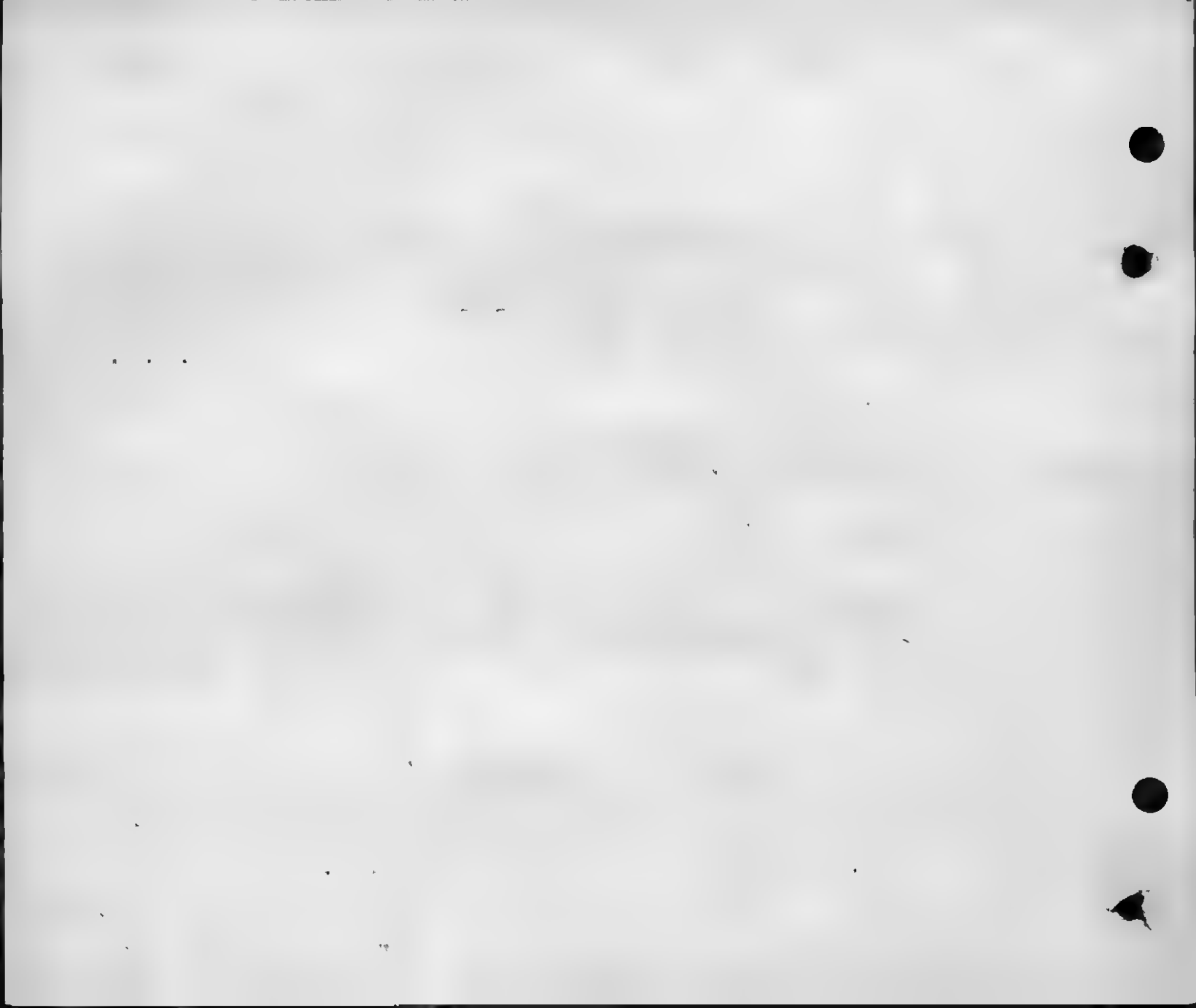
8 hours

19. WAS AUTOPSY PERFORMED?

YES ☒ NO ☐

22b. DATE SIGNED

12/30/61

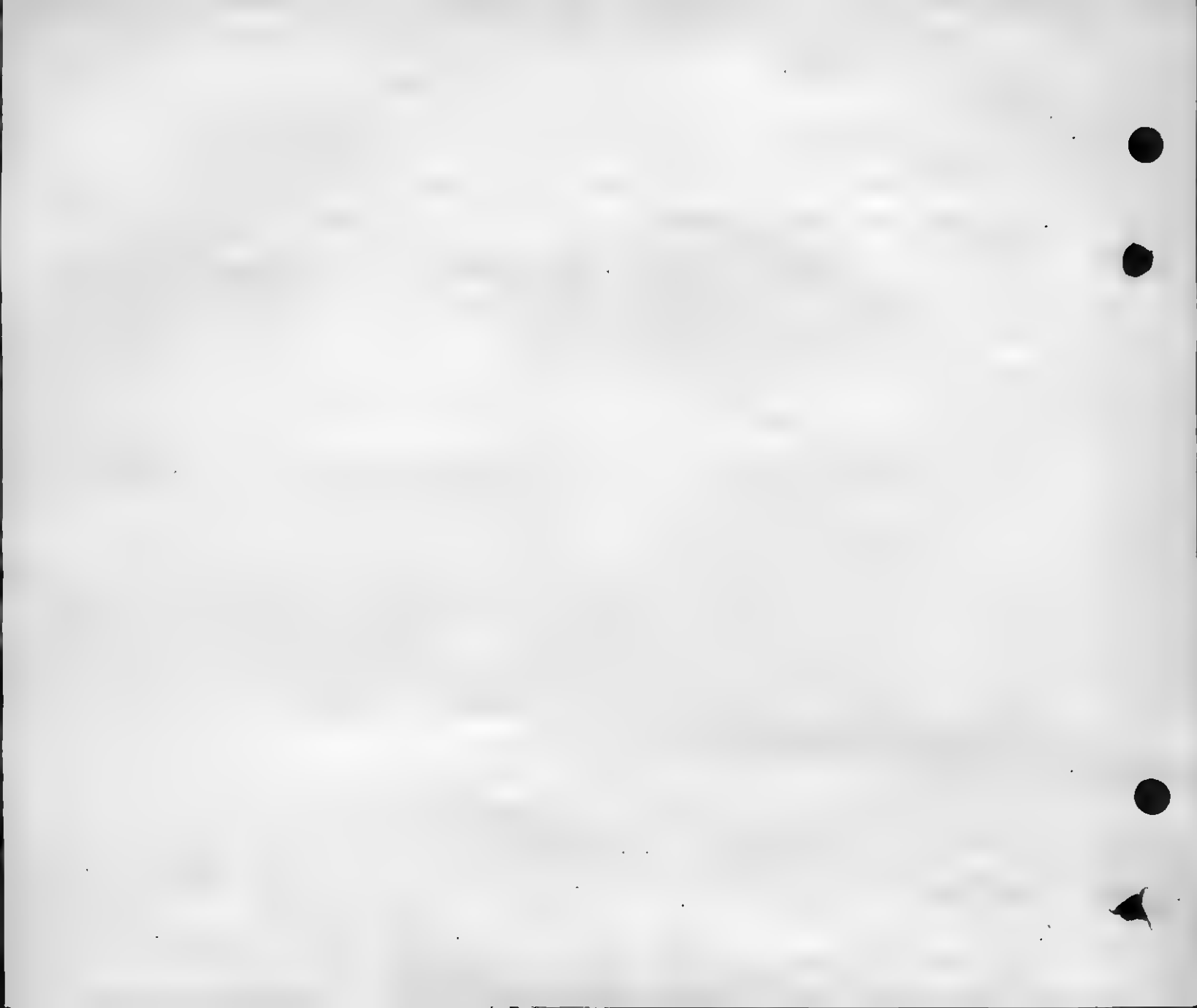


TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician. Page 1 and 2 should be completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7'61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
13450  
CERTIFICATE OF DEATH  
13430

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Florida b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Coral Gables d. STREET ADDRESS 304 Majorka Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last Marcel L. Le Blanc		4. DATE OF DEATH Month Day Year December 2 19 61	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		8. DATE OF BIRTH 5/24/07	
9. AGE (in years last birthday) 54 yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not working		10b. KIND OF BUSINESS OR INDUSTRY ADVERTISING NEWS PAPERS NEW ROCHELLE NY	
11. FATHER'S NAME GEORGE L. LE BLANC		12. MOTHER'S MAIDEN NAME VIOLET BARNETT	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) YES WW2		14. SOCIAL SECURITY NO 15. INFORMANT OFELIA S. LE BLANC	
16. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 3 days 2 days	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work Not While at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from 11/25, 1961, to 12/2, 1961, that (I) (we) last saw the deceased alive on 12/2, 1961, and that death occurred at 3:15 PM, from the causes and on the date stated above.		22a. SIGNATURE Richard N. Peeler M.D. 22b. DATE SIGNED DEC 5 '61	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) 12/5/61		23c. NAME OF CEMETERY OR CREMATORY HOLY ROOD CEM. 23d. LOCATION (City, town or county) (State) WESTBURY NY	
24. FUNERAL DIRECTOR'S SIGNATURE JOHN M. TAYLOR-SONS ANNAPOLIS MD.		25a. REC'D BY REGISTRAR DATE DEC 5 '61 25b. REGISTRAR'S SIGNATURE L. J. J. J.	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

FOR STATE HEALTH DEPT.

13451

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 1 & 2 Film G302

12/12/61 iwk

13432

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Crownsville State Hospital</b>	
2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis, Md.</b>	
3. NAME OF DECEASED (Type or print) <b>Arthur</b>		4. DATE OF DEATH <b>12 4 1961</b>		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
6. COLOR OR RACE <b>Male</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-5-01</b>	
9. AGE (In years last birthday) <b>60</b>		10. IF UNDER 1 YEAR Months <b>12</b> Days <b>4</b>		11. IF UNDER 24 HRS. Hours <b>12</b> Min. <b>4</b>	
12a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY		12c. BIRTHPLACE (State or foreign country) <b>Mississippi</b>	
13. FATHER'S NAME <b>George McEwen</b>		14. MOTHER'S MAIDEN NAME <b>Julia Buford</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Emmamecwen</b>		18. ADDRESS <b>146 Beesgate Rd.</b>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> 422.1 DUE TO (b) (c) DUE TO (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) INTERVAL BETWEEN ONSET AND DEATH					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Russell S. Fisher</b>		M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type, <b>RUSSELL S. FISHER, M.D.</b> )		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>12-8-1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Annapolis Neck</b>	
22d. LOCATION (City, town, or country) <b>Annapolis Md.</b>		22e. (State) <b>Md.</b>		22f. REC'D BY REGISTRAR <b>DEC 5 '61</b>	
22g. REGISTRAR'S SIGNATURE <b>William Beese</b>		22h. ADDRESS (Street, city, town or county)			

10/10/10

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

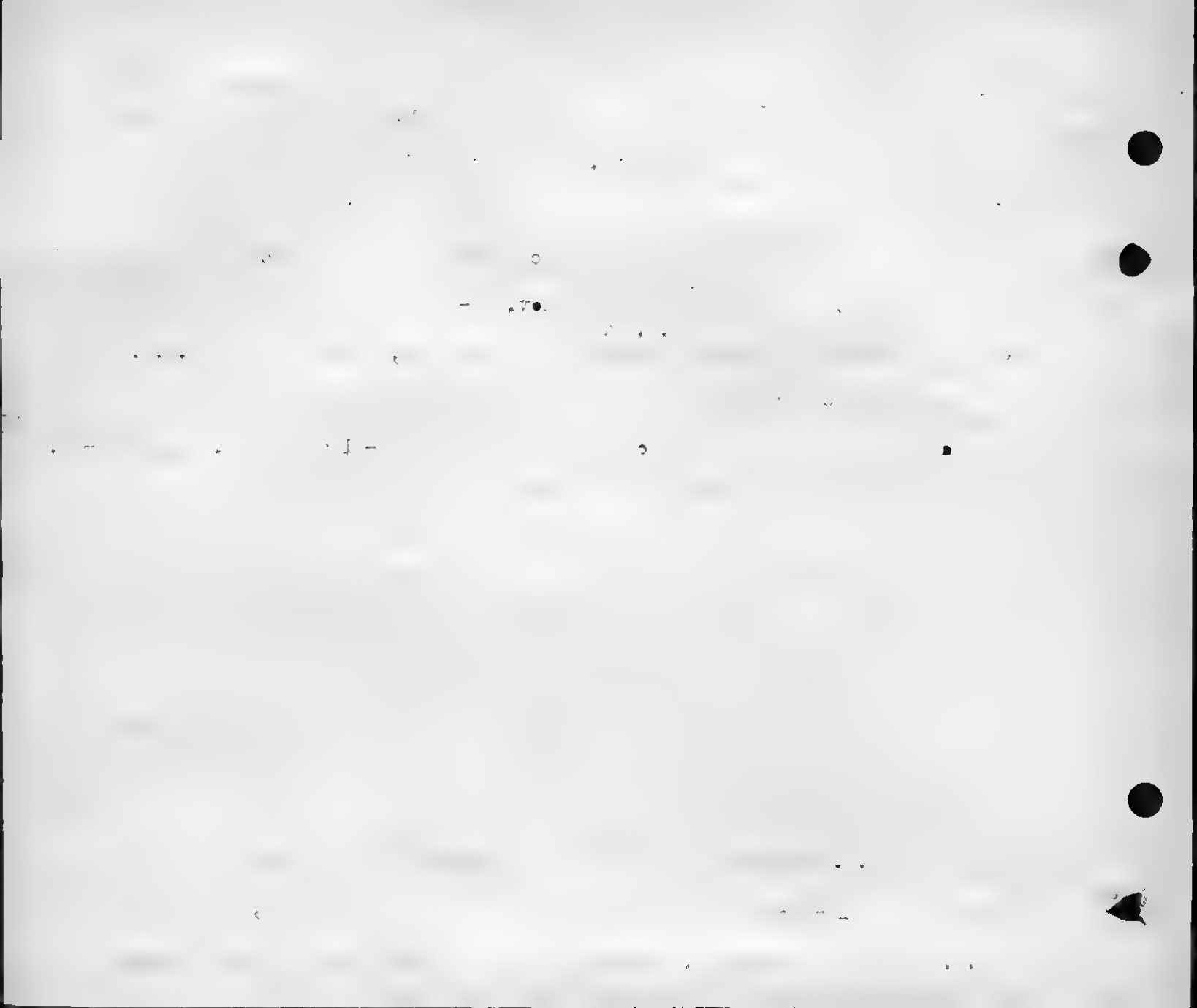
13452

## CERTIFICATE OF DEATH

Items 8 & 9 fill in 3-05 1/10/62

13433

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY IN b <b>34 Yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>115 Clay Street</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> d. STREET ADDRESS <b>115 Clay Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM</b> First Middle Last <b>McPHERSON</b>		4. DATE OF DEATH <b>Dec 24 19 61</b> Month Day Year	
5. SEX <b>M</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 20-1886</b> 9. AGE (In years last birthday) <b>75</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Building Attendant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Naval Academy</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Annapolis, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Alexander McPherson</b>		14. MOTHER'S MAIDEN NAME <b>Harriett Green</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Hattie McPherson-115 Clay St. Annapolis-Md.</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage due to</b> DUE TO (b) <b>Arteriosclerotic Hypertensive Vascular Disease</b> DUE TO (c) <b>5 days</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, lecture, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <b>Dec 19</b> 19 <b>61</b> to <b>Dec 24</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Dec 24</b> 19 <b>61</b> , and that death occurred at <b>2:10 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>R.L. Richardson</b>		22b. DATE SIGNED <b>12/26/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>R.L. Richardson</b>		22d. ADDRESS <b>110 Clay Street-Annapolis, Maryland</b>	
22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-27-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Brewer Hill</b>		23d. LOCATION (City, town or county) (State) <b>Annapolis, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>C.E. Hicks</b>		25a. REC'D BY REGISTRAR <b>Anthony L. Kenna</b>	
ADDRESS <b>111 Annapolis, Maryland</b>		25b. REGISTRAR'S SIGNATURE	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13453

13434

FOR STATE  
HEALTH DEPT.

### 1. PLACE OF DEATH

a. COUNTY

Anne Arundel County,

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Anne Arundel General Hospital

NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

OTTO

MEYER

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

Aug 6, 1888

9. AGE (In years last birthday)

73

10. IF UNDER 1 YEAR

Months Days

11. IF UNDER 24 HRS.

Hours Mins.

4. DATE  
OF  
DEATH

Month

Day

Year

December 11,

19 61

e. IS RESIDENCE  
ON A FARM?  
YES ☐ NO ☐

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Landscape

10b. KIND OF BUSINESS OR INDUSTRY

Gardener

11. BIRTHPLACE (State or foreign country)

Switzerland

12. CITIZEN OF WHAT COUNTRY?

U S A

13. FATHER'S NAME

Johann Meyer

14. MOTHER'S MAIDEN NAME

Elizabeth

(Unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Hospital records Anne Arundel Co Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Multiple Traumatic Injuries

812 X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

INTERVAL BETWEEN  
ONSET AND DEATH

19. WAS AUTOPSY  
PERFORMED?  
YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS  
PRIMARY ☒ or CONTRIBUTING ☐  
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Pedestrian struck by motor car.

20c. TIME OF INJURY Month, Day, Year  
Hour S.m.  
p.m. Dec. 11, 19 61

20d. INJURY OCCURRED

While Not While  
at work ☐ at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

street

20f. (City or town)

Conways, Maryland

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATURE

EXAMINER'S  
NAME (Type)

HOWARD G. SHAUB, M. D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

DEPUTY MEDICAL EXAMINER ☐

DATE SIGNED

12/12/61

22a. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

22b. DATE THEREOF

Dec 15, 1961

22c. NAME OF CEMETERY OR CREMATORY

Ft Lincoln Cemetery

22d. LOCATION (City, town, or country)

Colmar Manor, Md.

23. FUNERAL DIRECTOR

ADDRESS

F Gasch's Sons Hyattsville Md.

24a. REC'D BY REGISTRAR

DEC 18 '61

24b. REGISTRAR'S SIGNATURE

Charles S. Hanna

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



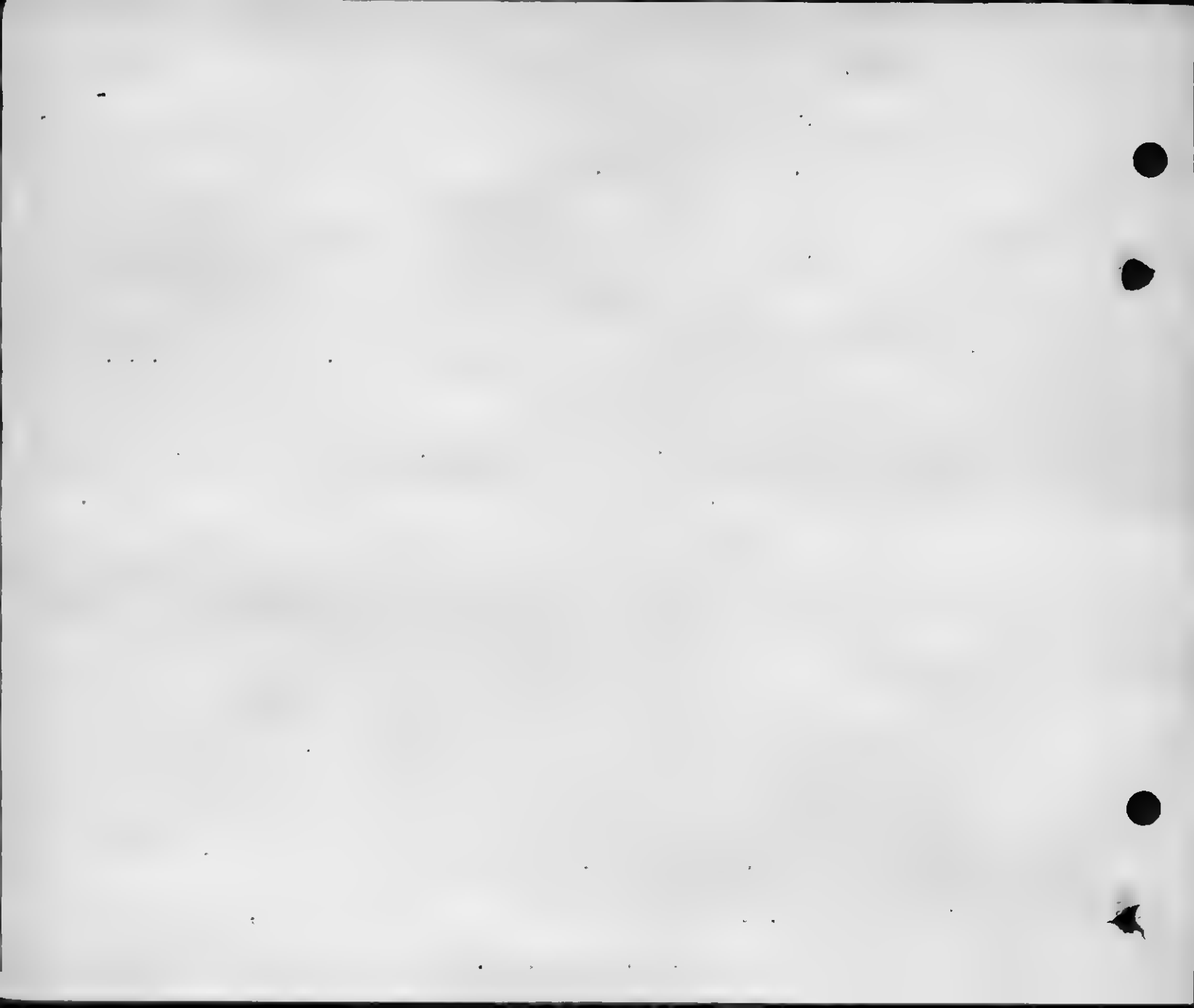
# FOR STATE HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13454 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13435									
1. PLACE OF DEATH a. COUNTY Anne Arundel County					2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Same				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park, Md.					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same				
c. LENGTH OF STAY IN b 3 1/2 yrs.					d. STREET ADDRESS Same				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box 518, Jumper Hole Road					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) William Moore					4. DATE OF DEATH Dec. 5, 1961				
5. SEX Male					6. COLOR OR RACE White				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH 10/26/96				
9. AGE (In years last birthday) 65 yrs.					10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Hardware Store Clerk				
11. BIRTHPLACE (State or foreign country) Baltimore, Md.					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Morris Moore					14. MOTHER'S MAIDEN NAME Catherine (unknown)				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No					16. SOCIAL SECURITY NO. 212-01-2704				
17. INFORMANT Mrs. Hazel M. Talheimer (stepdaughter)					18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH 3 hrs.				
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE Gustave H. Faubert, M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Glen Burnie, Md. DATE SIGNED 12/6/61				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF 7th Dec. 61				
22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery					22d. LOCATION (City, town, or country) (State) Baltimore, Maryland				
23. FUNERAL DIRECTOR Richard V. Dingle					24a. REC'D BY REGISTRAR DEC 11 1961				
24b. REGISTRAR'S SIGNATURE Glen Burnie, Md.					DATE				



## CERTIFICATE OF DEATH

13436  
Reg. Dist. No.

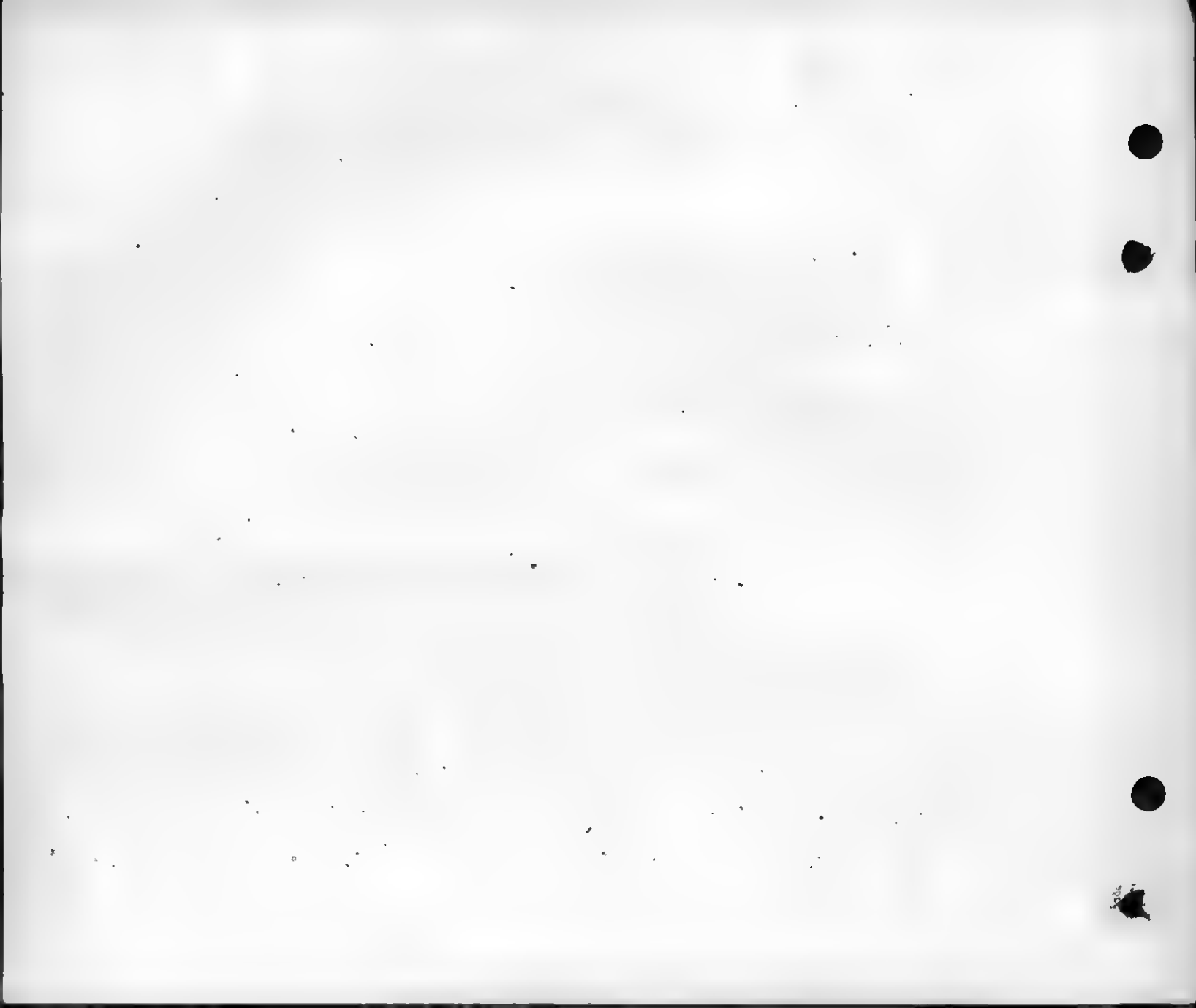
13455

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>ARUNDEL</b>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>GLEN BURNIE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X GLEN BURNIE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CATHERINE M. MORSELL</b>		4. DATE OF DEATH Month Day Year <b>DEC. 22 1961</b>	
5. SEX <b>Fe.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 9, 1888</b>
9. AGE (In years last birthday) <b>73 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House.</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Chas. W. Schaeffer</b>		14. MOTHER'S MAIDEN NAME <b>Bab. v. Balgout</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>Family - DWIG</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> DUE TO <b>170X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of the left breast</b> (c) <b>Arteriosclerotic heart disease</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March</b> , 1961, to <b>Dec. 22</b> , 1961, that I last saw the deceased alive on <b>Oct. 20</b> , 1961, and that death occurred at <b>8:50 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edmond I. Moushabek</b>		ADDRESS (Street, city or town, state) <b>21015, Ritchie Highway</b>	
PHYSICIAN'S NAME (Type) <b>EDMOND I. MOUSHABEK</b>		DATE SIGNED <b>12/23/61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>12/26/61</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Glen Burnie</b>		22d. LOCATION (City, town, or county) (State) <b>Burnie</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>McQuay - 130 E. Tomlin</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>DEC 26 '61</b>		24b. REGISTRAR'S SIGNATURE <b>C. S. Rouse</b>	

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13456

## CERTIFICATE OF DEATH

Reg. Dist. No. 13437

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft George G. Meade		c. LENGTH OF STAY IN 1b 3 Hrs 44 Min	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Odenton
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kimbrough Army Hospital		d. STREET ADDRESS Box 133A	
3. NAME OF DECEASED (Type or print) First NOT NAMED Middle Last Nail		4. DATE OF DEATH Month December Day 20 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 Dec 1961
9. AGE (In years lost birthday) yrs.		IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS Days Hours Mins
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Fred H. Nail	
14. MOTHER'S MAIDEN NAME Shirley Faye Phelps		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -	
16. SOCIAL SECURITY NO -		17. INFORMANT Mother Address Same as Item 2D	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 750 X DUE TO Respiratory Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO Anencephaly (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 Hrs 44 Min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prematurity		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 20 December, 19 61 to 20 December, 19 61, that I last saw the deceased alive on 20 December, 19 61 and that death occurred at 0830A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Kimrough Army Hospital FGGM, MD 20 Dec 61 ACTUAL SIGNATURE Stuart Bernstein M.D. PHYSICIAN'S NAME (Type) STUART BERNSTEIN, CAPTAIN, MC			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 20 Dec 61	
22c. NAME OF CEMETERY OR CREMATORY KIMBROUGH ARMY HOSPITAL		22d. LOCATION (City, town, or county) (State) Ft Geo G. Meade, Md	
23. FUNERAL DIRECTOR'S SIGNATURE William Steeger Mt.		24a. REC'D BY REGISTRAR DATE DEC 22 01	
24b. REGISTRAR'S SIGNATURE		24c. REGISTRAR'S SIGNATURE	



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TO HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

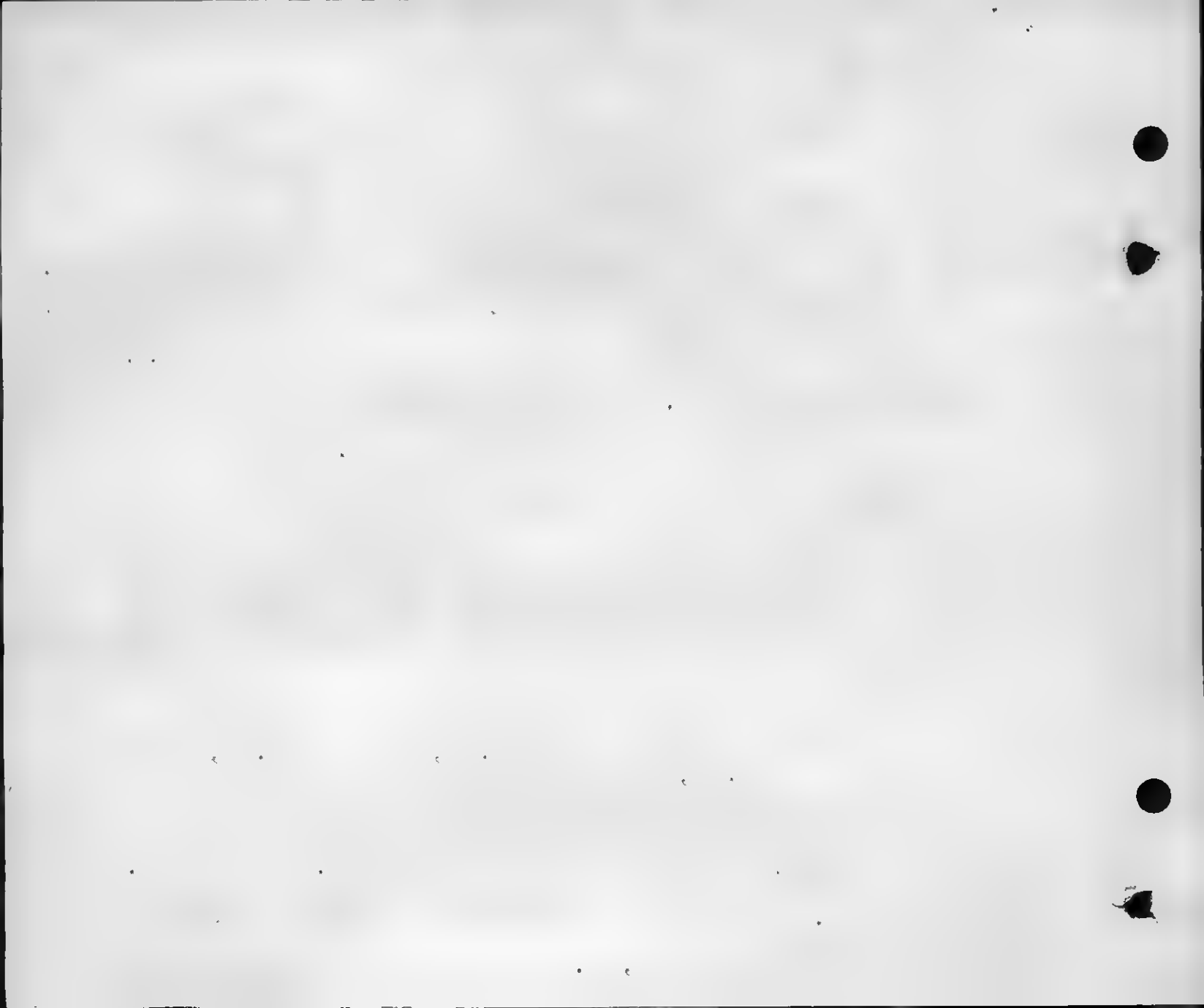
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
13457  
13438  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Annapolis</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>		d. STREET ADDRESS <u>Rt-1, Box-321</u>	
3. NAME OF DECEASED (Type or print) First <u>BABY</u> Middle <u>BOY</u> Last <u>NEWQUIST</u>		4. DATE OF DEATH Month <u>December</u> Day <u>15</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 15, 1961</u>
9. AGE (In years last birthday) <u>4</u> yrs.		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newborn</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Newborn</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Stanley Arthur Newquist, Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Patricia June Seger</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>17. INFORMANT</u> <u>Hospital records.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>prematurity</u> 776X DUE TO (b) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) <u>attended</u> the deceased from <u>Dec. 15, 1961</u> to <u>Dec. 15, 1961</u> that (I) <u>did</u> not see the deceased alive on <u>Dec. 15, 1961</u> , and that death occurred at <u>8:50 AM</u> from the causes and on the date stated above. 22a. SIGNATURE <u>Niel H. Sims</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>12/15/61</u> 22c. PHYSICIAN'S NAME (Type) <u>Niel H. Sims</u> 22d. ADDRESS <u>95 Cathedral St., Annapolis, Md.</u> 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Dec. 18, 61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Annapolis, Maryland</u> 24. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u> ADDRESS <u>Annapolis, Md.</u> 25a. RECEIVED BY REGISTRAR <u>DEC 19 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Charles L. Hume</u>			

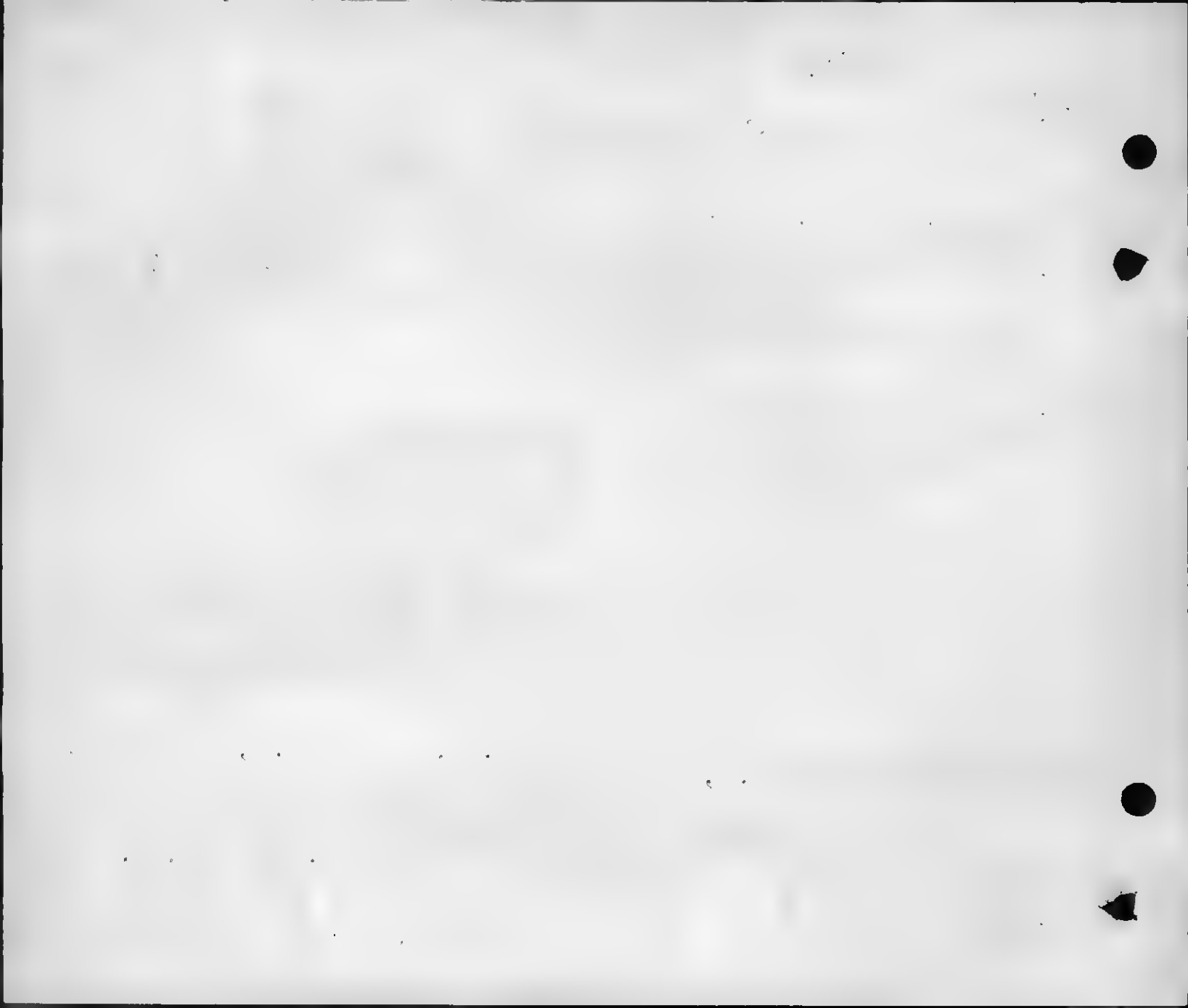


## 13439

VR A15 (4)  
ISM 7 61

**TO HOSPITAL:** [redacted] **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 72 hours after death. Page 4 [redacted] be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13459

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13440

FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is not a bar to the execution of this certificate. The certificate should be executed in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel County, MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel Co.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>109 Monticello Avenue</b>		d. STREET ADDRESS <b>109 Monticello Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>BRIAN K. PALMER</b>		4. DATE OF DEATH <b>December 20, 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 11, 1961</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		11. BIRTHPLACE (State or foreign country) <b>Annapolis, Maryland</b>	
10b. KIND OF BUSINESS OR INDUSTRY -----		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James A. Palmer III</b>		14. MOTHER'S MAIDEN NAME <b>Helen Mason</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) -----		16. SOCIAL SECURITY NO. <b>James A. Palmer III- Father- Same as # 2</b>	
17. INFORMANT <b>James A. Palmer III- Father- Same as # 2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Interstitial Pneumonitis</b> <b>Sxox</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>December 22, 61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Memorial</b>		22d. LOCATION (City, town, or country) <b>Annapolis, Maryland</b>	
22e. ADDRESS <b>Hopping Funeral Home</b>		22f. ADDRESS <b>Annapolis, Maryland</b>	
23. SIGNATURE OF MEDICAL EXAMINER <b>Howard G. Shaub</b>		23b. DATE SIGNED <b>12/21/61</b>	
23c. NAME (Type) <b>HOWARD G. SHAUB, M.D.</b>		23d. ADDRESS (Street, city, town, or county)	
24a. REC'D BY REGISTRAR <b>DEC 26 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Walter S. Frame</b>	

100



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained at the hospital or attending physician.  
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

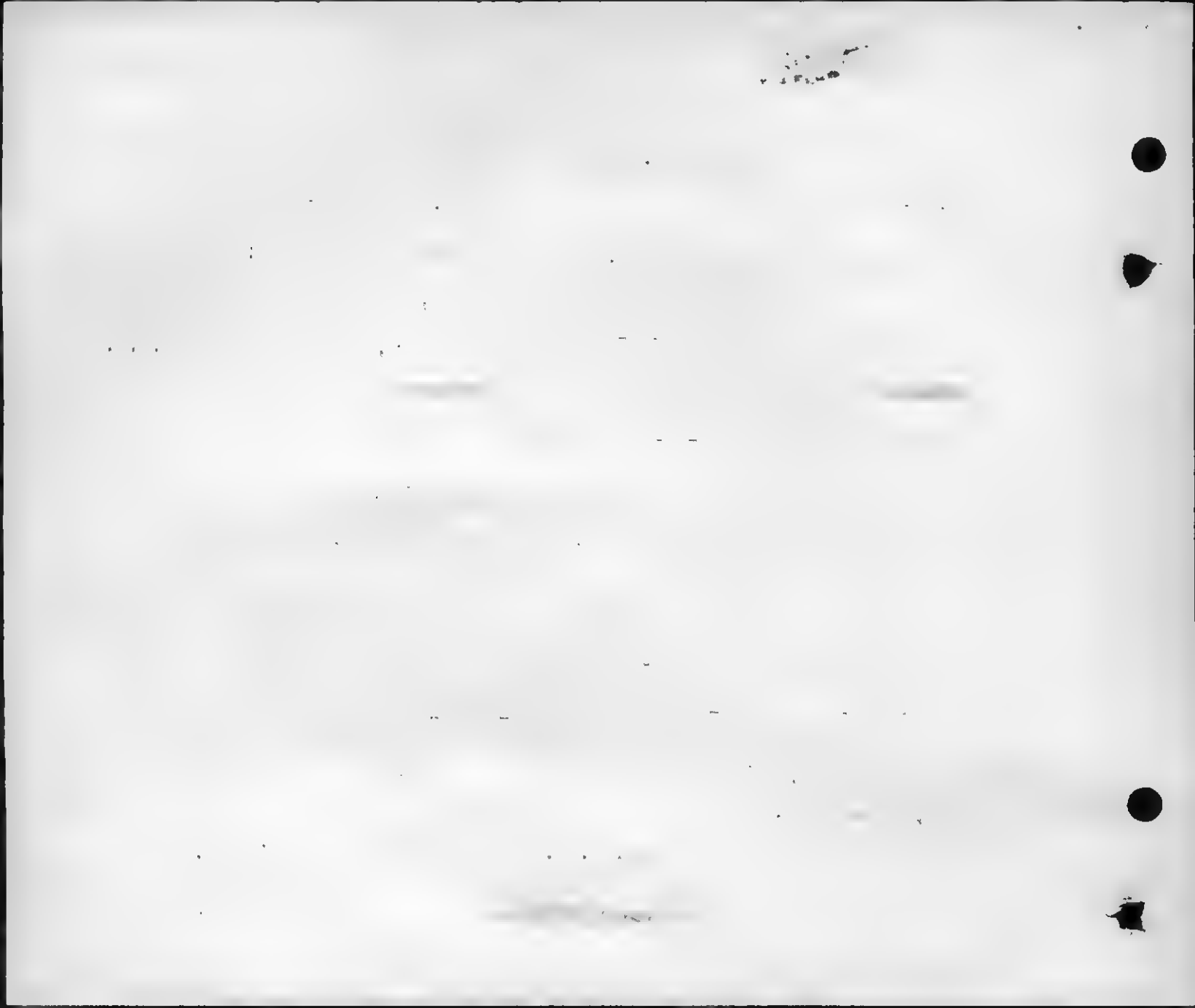
VR A15 (4)  
15M 9/59

13460

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13441

1 PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY IN 1b <b>1 mo. 5 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>929 N. Rosedale Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>Louis</b> Middle <b>E.</b> Last <b>Pinkney</b>		4. DATE OF DEATH Month <b>12</b> Day <b>8</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6 COLOR OR RACE <b>Negro</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 3, 1889</b>
9 AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months <b>12</b> Days <b>8</b> Hours <b>19</b> Min. <b>61</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>		10b KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11 BIRTHPLACE (State or foreign country) <b>Maryland,</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Pinkney</b>		14. MOTHER'S MAIDEN NAME <b>Lina Thomas</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes World War I</b>		16. SOCIAL SECURITY NO. <b>214-01-7514</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Infarction</b> DUE TO <b>C.B. &amp; Associated arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>-----</b> (c) <b>-----</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>o. 12</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <b>at work</b> <input checked="" type="checkbox"/> <b>not at work</b> <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>		20f. (City or town) (County) (State) <b>-----</b>	
21 I certify that (I) (this hospital) attended the deceased from <b>11/3</b> <b>19 61</b> to <b>12/8</b> <b>19 61</b> , that (I) (we) last saw the deceased alive on <b>12/8</b> <b>19 61</b> , and that death occurred at <b>1 P</b> M, from the causes and on the date stated above.			
22a SIGNATURE <b>Hildegard Heard Reissman</b>		22b DATE <b>12/8/61</b>	
22c PHYSICIAN'S NAME (Type) <b>Hildegard Heard Reissman, M. D.</b>		22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>12.12.61</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
24 FUNERAL DIRECTOR'S SIGNATURE <b>Charles R. Lan</b>		25a REC'D BY REGISTRAR <b>DATE DEC 13 '61</b>	
ADDRESS <b>802 W. 4th St. Balt.</b>		25b REGISTRAR'S SIGNATURE <b>W. S. Kraus</b>	



13461

# MARYLAND STATE DEPARTMENT OF HEALTH

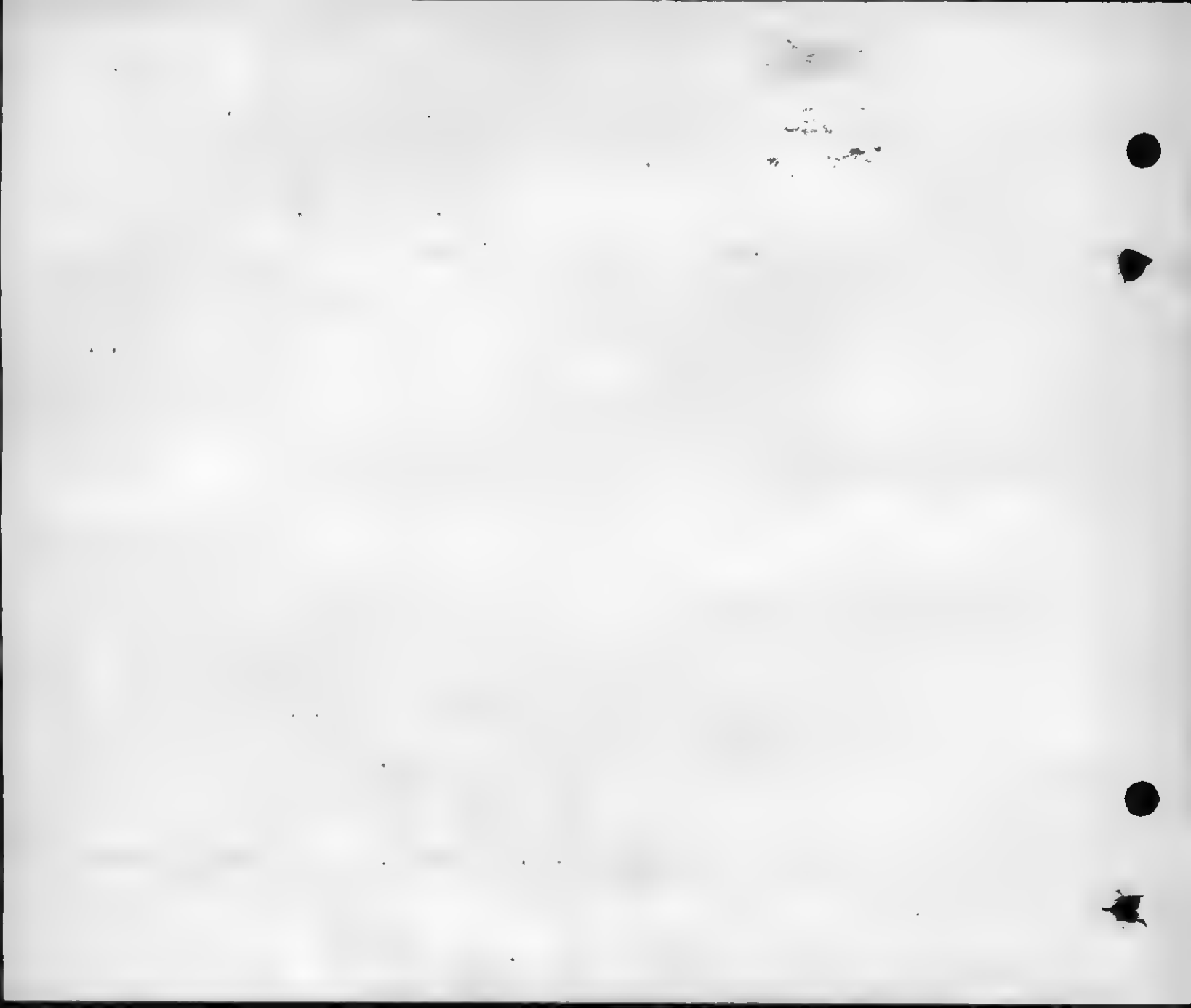
## DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

### CERTIFICATE OF DEATH

13442

<b>1 PLACE OF DEATH</b> a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		<b>2 USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
c. LENGTH OF STAY IN 1b <b>5 years 3 mos. 2 days</b>		d. STREET ADDRESS <b>552 W. Lanvale St.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3 NAME OF DECEASED</b> (Type or print) First <b>Arzzy</b> Middle <b></b> Last <b>Pittman</b>		<b>4 DATE OF DEATH</b> Month <b>12</b> Day <b>12</b> Year <b>1961</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>Negro</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>1890 (June 3)</b>
<b>9 AGE</b> (In years last birthday) <b>71</b> yrs		<b>IF UNDER 1 YEAR</b> Months <b></b> Days <b></b> Hours <b></b> Min <b></b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Unknown Laborer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Unknown</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) <b>Unknown Mannikin Va.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13 FATHER'S NAME</b> <b>Unknown Alex Pittman</b>		<b>14 MOTHER'S MAIDEN NAME</b> <b>Unknown Catherine Mills</b>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>		<b>16. SOCIAL SECURITY NO</b> <b>Unknown</b>	
<b>17. INFORMANT</b> <b>Hospital Records</b>		Address <b></b>	
<b>18 CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <b>4A3X</b> DUE TO <b>Heart</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Artery</b> DUE TO <b></b> (c) <b></b>			
<b>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>			
<b>19 WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b></b>	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. <b></b> p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b></b>		<b>20f. (City or town)</b> (County) (State) <b></b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>4/10</b> <b>1961</b> <b>to</b> <b>12/12</b> <b>1961</b> , <b>that (I) (we) last saw the deceased alive on</b> <b>12/12</b> <b>1961</b> , <b>and that death occurred</b> <b>12/12/61</b> , <b>from the causes and on the date stated above</b>			
<b>22a. SIGNATURE</b> <b>Hildegard Heard Reissman</b>		<b>22b. DATE</b> <b>12/12/61</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Hildegard Heard Reissman, M. D.</b>		<b>22d. ADDRESS</b> <b>Crownsville State Hospital, Maryland</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Buried</b>		<b>23b. DATE THEREOF</b> <b>12-16-61</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>St. Anselm</b>		<b>23d. LOCATION</b> (City, town, or county) (State) <b>Baltimore Md</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Joseph C. Rynn</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>12/14/61</b>	
<b>ADDRESS</b> <b>2222 W. North Ave</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>W. E. Kneale</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician. The law also requires that the death certificate be signed by the attending physician and completely filled in by the director, health officer, or funeral director. After this certificate has been signed by the attending physician and completely filled in by the director, health officer, or funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



Page 4  
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/59

13462

DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

13443

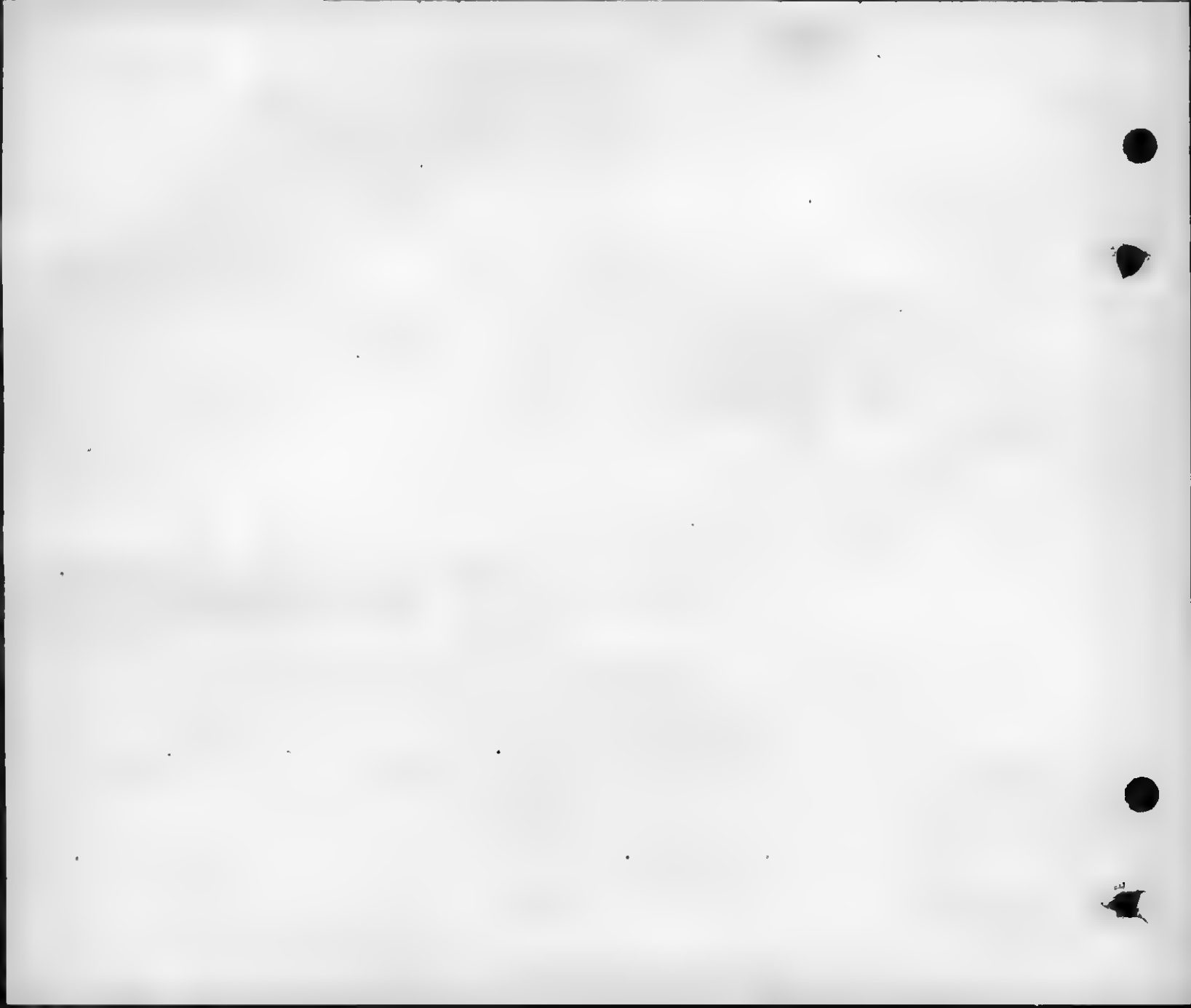
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Mary</u> Last <u>Bratt</u>				4. DATE OF DEATH Month <u>12</u> Day <u>19</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>3-14-1907</u>	
9. AGE (In years lost birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Wesley Parker</u>				14. MOTHER'S MAIDEN NAME <u>Ada Ann Mitchell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>No</u> (If yes, give war and dates of service)				16. SOCIAL SECURITY NO. <u>  </u>			
17. INFORMANT <u>Maria Smith Flowers</u> Address <u>Annapolis, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>443X</u> DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Hypertensive cardiovascular disease Grade IV</u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> (b) <u>  </u> (c) <u>  </u>							
INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>7 days</u> <u>10 yrs.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. <u>  </u> <u>  </u> <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 12</u> , 19 <u>61</u> , to <u>Dec. 18</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>December 18, 1961</u> , and that death occurred at <u>2:30a</u> M., from the causes and on the date stated above.							
22a. SIGNATURE <u>Theodore H. Johnson</u> M. D.				22b. DATE SIGNED <u>Dec 20 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>Theodore H. Johnson, M. D.</u>				22d. ADDRESS <u>37 Calvert Street, Annapolis, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-24-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Davidsonville</u>		23d. LOCATION (City, town, or county) (State) <u>Davidsonville, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. - Annapolis, Md.</u>				25a. REC'D BY REGISTRAR <u>DEC 20 1961</u>			
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

(M)

(I)

13

1



TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

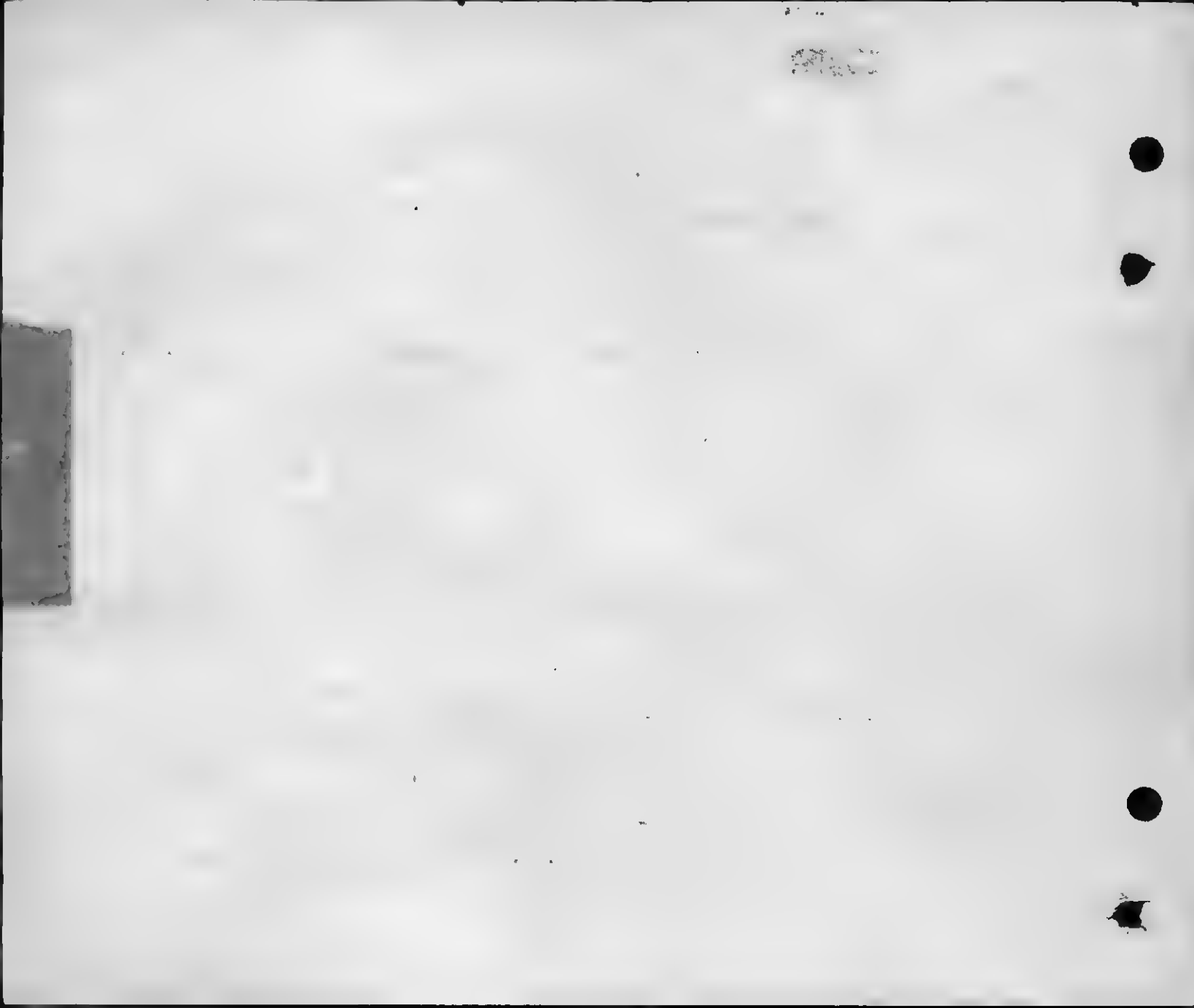
1  
12/1/62

M

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13463 <b>CERTIFICATE OF DEATH</b> 14652									
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>			c. LENGTH OF STAY IN b <b>12 years 5 mos. 3 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Crownsville State Hospital</b>									
3. NAME OF DECEASED (Type or print) <b>Sylvester</b>			First Middle Last <b>Rice</b>			4. DATE OF DEATH Month Day Year <b>12 30 1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1884</b>		9. AGE (In years last birthday) <b>77</b> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>				11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>213-30-5825</b>		17. INFORMANT <b>Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> 441X Conditions, if any, which gave rise to immediate cause (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Arteriosclerotic Cardiovascular Disease</b>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Month, Day, Year Hour <b>9:15</b> p.m. 19 <b>61</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) _____		20f. (City or town) (County) (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <b>7/27</b> , 19 <b>49</b> , to <b>12/30</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>12/30</b> , 19 <b>61</b> , and that death occurred at <b>7:30</b> P.M. from the causes and on the date stated above.									
22a. SIGNATURE <b>Hildegard Heard Reissman</b>				M.D. <b>M.D.</b>		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1/1/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Hildegard Heard Reissman, M.D.</b>				22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Funeral Home</b>				23b. DATE THEREOF <b>1/1/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Annapolis</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore City</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Funeral Home</b>				ADDRESS <b>Funeral Home</b>		25a. REC'D BY REGISTRAR <b>JAN 11 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. P. P.</b>	

VR A15 (4)  
15M 9/60



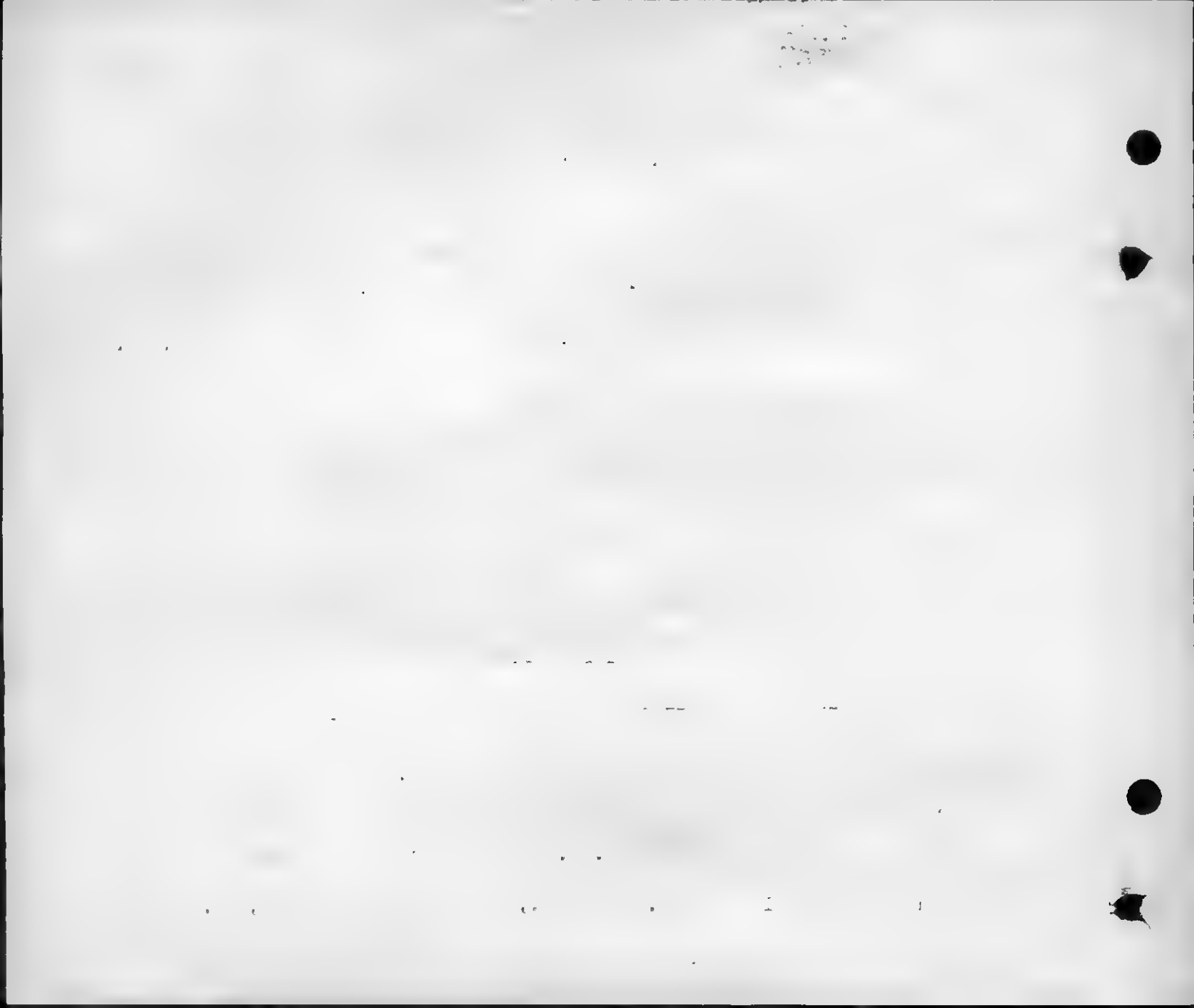
**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

13464

13444

1 PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>1 year 1 mo. 14 days</b>		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		d. STREET ADDRESS <b>Unknown</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>Kenneth</b>		Middle <b></b>		Last <b>Ricks</b>		4. DATE OF DEATH Month <b>12</b>		Day <b>4</b>		Year <b>19 61</b>					
5 SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 1, 1907</b>		9 AGE (in years last birthday) yrs <b>54</b>		IF UNDER 1 YEAR Months <b></b>		IF UNDER 24 HRS Days <b></b>		Hours <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>				11. BIRTHPLACE (State or foreign country) <b>Unknown</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Unknown</b>						14. MOTHER'S MAIDEN NAME <b>Unknown</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>				17. INFORMANT <b>Hospital Records</b>				Address <b></b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO <b>4-25-1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO <b></b> (c) <b></b>												INTERVAL BETWEEN ONSET AND DEATH <b></b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>											
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>-----</b> 19 p. m. <b>-----</b>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>		20f. (City or town) <b>-----</b>		(County) <b>-----</b>		(State) <b>-----</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>10/20</b> to <b>12/4</b> 19 <b>61</b> . that (I) (we) last saw the deceased alive on <b>12/4</b> 19 <b>61</b> and that death occurred at <b>11:15</b> A.M. from the causes and on the date stated above															
22a. SIGNATURE <b>Lionel McHenry Mapp</b>												22b. DATE <b>12/4/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M. D.</b>												22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>12/9/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Pleasant.,</b>				23d. LOCATION (City, town, or county) (State) <b>Norbeck, Md.</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Smith</b>						ADDRESS <b>Rockville, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 11 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>					

MEDICAL CERTIFICATION



13465

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

13445

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>2 y, 4 mo, 10 d</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>13445</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Crownsville State Hospital</b>				d. STREET ADDRESS <b>1368 Whatcoat St.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Priscilla Rogers</b>		4. DATE OF DEATH Month Day Year <b>12 30 19 61</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>N</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>1933 SEPT 19</b>		9. AGE (In years last birthday) <b>28</b> yrs.		IF UNDER 1 YEAR Months Days <b>28 12</b>		IF UNDER 24 HRS Hours Min <b>30 19</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Hospital Records</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>4+9) 1X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>Spastic diplegia, congen., Epilepsy, Mental deficiency</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>8/21 1959 to 12/30 19 61</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Crownsville</b>		(County) <b>Anne Arundel</b>		(State) <b>Md</b>		21. I certify that (I) (this hospital) attended the deceased from <b>8/21 1959</b> to <b>12/30 19 61</b> that (I) (we) last saw the deceased alive on <b>12/30 19 61</b> , and that death occurred at <b>5:30 AM</b> from the causes and on the date stated above.		22a. SIGNATURE <b>Hildegarde Heard Reissmann</b> M.D.	
22b. DATE SIGNED <b>12/30/61</b>		22c. PHYSICIAN'S NAME (Type) <b>Dr. Hilda Reissmann</b>		22d. ADDRESS <b>Crownsville State Hospital</b>		23a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-3-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Carver Cem</b>		23d. LOCATION (City, town, or county) <b>Laurel Md</b>		(State) <b>Md</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>Edw. S. Talson</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 3 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Carroll S. Hanna</b>		25c. ADDRESS <b>1348 N. Calhoun St</b>		25d. CITY <b>Baltimore</b>		25e. STATE <b>Md</b>		25f. ZIP CODE <b>21201</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. It should be retained in the hospital or attending physician's office for 10 years. It should be filed in the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



13466

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

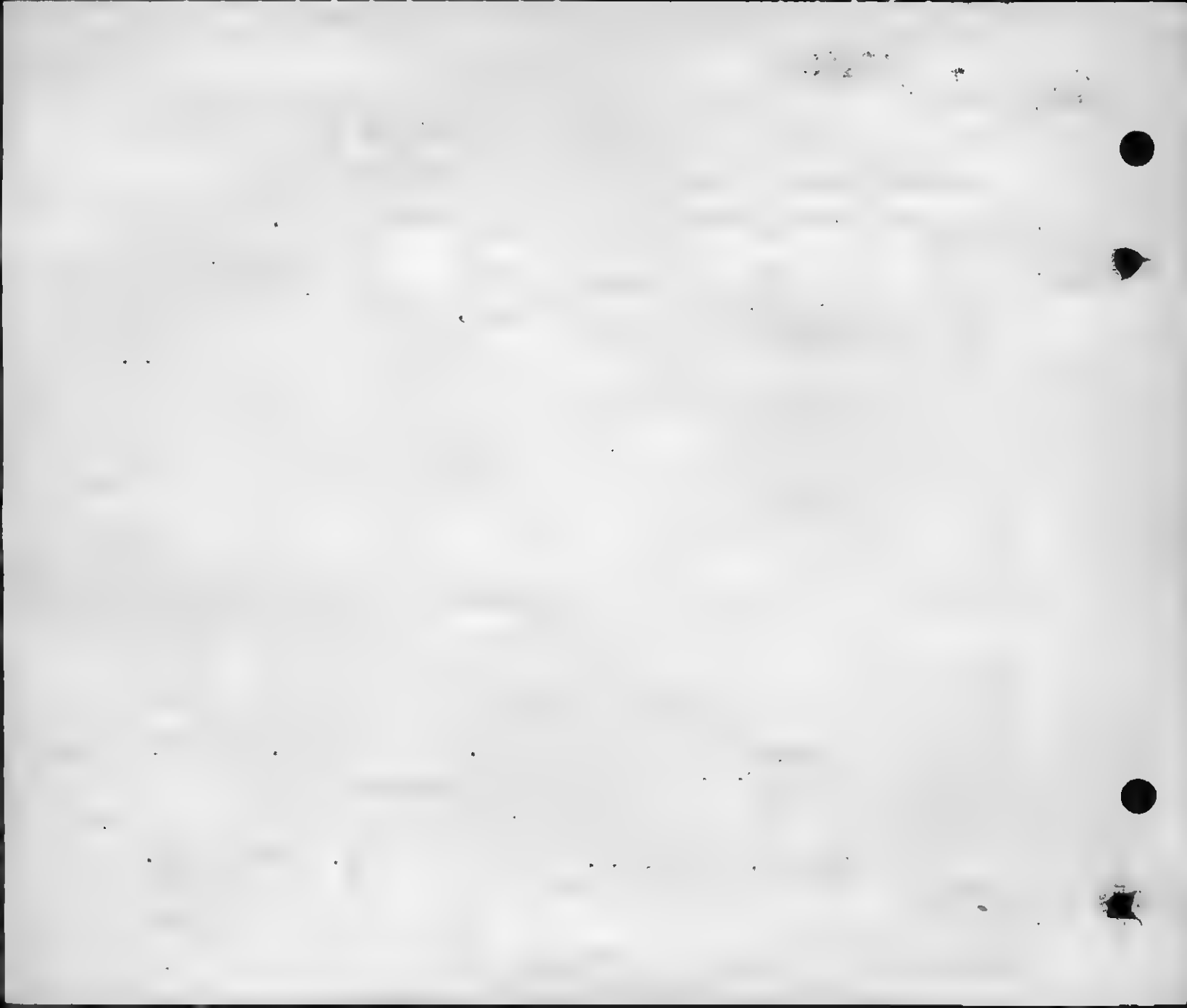
Reg. Dis. No.

13466

1. PLACE OF DEATH o. COUNTY <u>Sancti Hill, Pasadena R 7P</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) o. STATE <u>Same</u> b. COUNTY <u>---</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>---</u>	c. LENGTH OF STAY IN 1b <u>20 yrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>---</u>		d. STREET ADDRESS <u>1</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Eva</u> Middle <u>Rose</u> Last <u>Scott</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>2</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 7, 1875</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u>---</u> Days <u>---</u> Hours <u>---</u> Min <u>---</u>	IF UNDER 24 HRS. Months <u>---</u> Days <u>---</u> Hours <u>---</u> Min <u>---</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert R. Rowe</u>		14. MOTHER'S MAIDEN NAME <u>Lella Massey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service) <u>---</u>		16. SOCIAL SECURITY NO <u>---</u>	
17. INFORMANT <u>Mrs Virginia B Smick</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>Arterio-sclerotic Cardiovascular Disease</u> DUE TO (c) <u>---</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u> <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>---</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>---</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>---</u> p. m. <u>---</u> 19 <u>61</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u>	20f. (City or town) <u>---</u> (County) <u>---</u> (State) <u>---</u>
21. I certify that I attended the deceased from <u>Nov 2</u> , 19 <u>61</u> , to <u>Dec 2</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Dec 2</u> , 19 <u>61</u> , and that death occurred at <u>8:30</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>105 Eastview Ave</u> DATE SIGNED <u>12/2/61</u>			
ACTUAL SIGNATURE <u>James S. Bellingham</u>		PHYSICIAN'S NAME (Type) <u>James S. Bellingham</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>5 Dec. 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>London Park Cem.</u>		22d. LOCATION (City, town, or county) <u>Baltimore</u> (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. V. Singleton</u> ADDRESS <u>Glen Burnie Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 1, '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Carroll S. Pinner</u>			



VR A15 (4  
15M 7 61



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

13467

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13448

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>C.C.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
c. LENGTH OF STAY IN 1b <u>Years</u>		d. STREET ADDRESS <u>State Circle</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Gladys R Shiftlet</u>		4. DATE OF DEATH <u>Dec. 16 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Feb 3, 1928</u>
9. AGE (In years last birthday) <u>33</u> yrs.		10. AGE (In years last birthday) <u>33</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WAITRESS</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RESTAURANT</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Churchton Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CLARENCE CLINTON CRANDALL</u>		14. MOTHER'S MAIDEN NAME <u>Thelma Matthews</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>217 240 0181</u>	
17. INFORMANT <u>Mrs Gladys Hulse Shady Side Md</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Insulin shock</u> 260X DUE TO <u>Diabetic acidosis &amp; coma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Diabetes mellitus</u> (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>6 days</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 11, 1961</u> , to <u>Dec. 16, 1961</u> , that (I) (we) last saw the deceased alive on <u>Dec. 15, 1961</u> , and that death occurred at <u>1:15</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Willard F. Smith</u>		22b. DATE SIGNED <u>12/16/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>WILLARD F. SMITH, MD</u>		22d. ADDRESS <u>Shady Side, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/19/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Quaker</u>		23d. LOCATION (City, town or county) (State) <u>Folesville Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Harduty</u>		25a. REC'D BY REGISTRAR <u>DEC 21 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Carl J. Frank</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. 1. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health printed to burial, cremation, or removal, and in any event, within 72 hours after death.

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13469

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13449

1. PLACE OF DEATH a. COUNTY <u>AA CO</u> b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) <u>CHURCHTON</u> c. LENGTH OF STAY IN 1b <u>1</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>CHURCHTON</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA CO</u> c. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) <u>CHURCHTON</u> d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>LAURE</u> Middle <u>JOHN</u> Last <u>SMITH</u>		4. DATE OF DEATH Month <u>11</u> Day <u>15</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>22 1900</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>61</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS.: Hours <u>0</u> Min. <u>0</u>
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>1</u>	17. INFORMANT Address <u>1</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) <u>General weakened condition due to</u> DUE TO (c) <u>Carcinoma of breast &amp; multiple metastases</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 15</u> , 19 <u>61</u> , to <u>12/1/61</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>12/1/61</u> , 19 <u>61</u> , and that death occurred at <u>12/8/61</u> , 19 <u>61</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Willard F. Smith</u>		22b. DATE SIGNED <u>12/8/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>WILLARD F. SMITH, MD</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Dec 3 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Buster</u>		23d. LOCATION (City, town or county) (State) <u>GAI</u>	
24. FUNERAL DIRECTOR'S SIGNATURE		25a. REC'D BY REGISTRAR	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		DATE <u>DEC 1 '61</u>	

(15)







TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on complete and in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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<div style="display: flex; justify-content: space-between;"> <div> <p>13471</p> <p><b>MARYLAND</b> DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND</p> <p><b>CERTIFICATE OF DEATH</b></p> </div> <div> <p>13451</p> </div> </div>									
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <b>MARYLAND</b>					<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> ✓				
b. CITY OR TOWN (If outside corporate limits, write <u>RURAL</u> and give nearest town) <u>Fort George G Meade</u>			c. LENGTH OF STAY IN 1b <u>Unknown</u>		c. CITY OR TOWN (If outside corporate limits, write <u>RURAL</u> and give nearest town) <u>X Odenton</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kimbrough Army Hospital</u>					d. STREET ADDRESS <u>1890A Annapolis Road</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Susan</u> Middle <u>L</u> Last <u>Sisk</u>					<b>4. DATE OF DEATH</b> Month <u>December</u> Day <u>27</u> Year <u>1961</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>25 July 1960</u>		9. AGE (In years last birthday) <u>1</u> yrs	
						IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>		IF UNDER 24 HRS Hours <u>1</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Sisk</u>					14. MOTHER'S MAIDEN NAME <u>Selva Meadows</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give year or dates of service)		17. INFORMANT <u>Father See item 13</u>			Address <u>See item 2D</u>		
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Undetermined</u> (b) <u>Hydrocephalus</u> (c) <u>Mental and physical retardation</u>									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Meningocele</u>									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>November 1960</u> to <u>December 1961</u> , that (I) (we) last saw the deceased alive on <u>27 December 1961</u> , and that death occurred at <u>1155 P. M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Thermon Robinson</u> M.D.					22b. DATE <u>28 Dec 1961</u>				
22c. PHYSICIAN'S NAME (Type) <u>S. ROBINSON, CAPT, MC</u>					22d. ADDRESS <u>Kimbrough Army Hospital Ft George G Meade, Md</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/2/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wilmington, Maryland</u>		23d. LOCATION (City, town, or county) (State) <u>Wilmington, Virginia</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Carl D. Robinson, Funeral Home Inc</u>					25a. REC'D BY REGISTRAR <u>DATE JAN 3 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>		



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

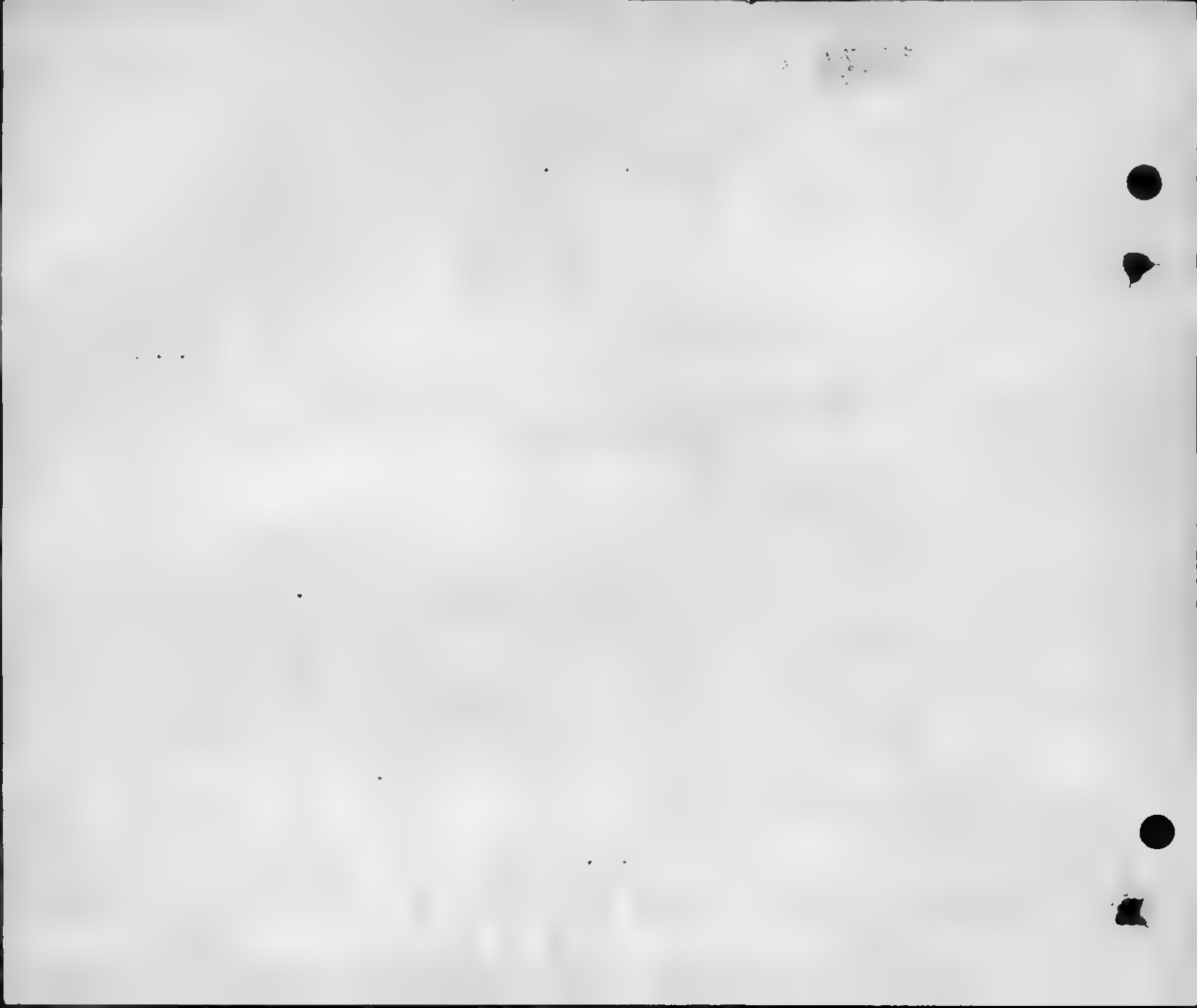
## CERTIFICATE OF DEATH

13472

13452

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u> c. LENGTH OF STAY IN 1b <u>16 yrs. 7 mos.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Crownsville State Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>723 George Street</u> e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Ada</u> Middle <u>Frances</u> Last <u>Smith</u>		<b>4. DATE OF DEATH</b> Month <u>12</u> Day <u>28</u> Year <u>1961</u>									
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>Negro</u>									
<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input checked="" type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>1894</u>									
<b>9. AGE</b> (In years last birthday) <u>67</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	<b>10. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
IF UNDER 1 YEAR		IF UNDER 24 HRS.									
Months	Days	Hours	Min.								
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Virginia</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>									
<b>13. FATHER'S NAME</b> <u>Charles Burton</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Marylish Smith</u>									
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>Unknown</u>									
<b>17. INFORMANT</b> <u>Hospital Records</u>		<b>18. CAUSE OF DEATH</b> (Enter on only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> (b) <u>Carcinoma of the Endometrium of Uterus</u> (c) <u>Paranoid Schizophrenia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Paranoid Schizophrenia</u>									
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
<b>20a. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>19</u> p.m.		<b>20b. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
<b>20c. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20d. (City or town)</b> (County) (State)									
<b>21. I certify that</b> (I) (this hospital) attended the deceased from <u>5/29 1945</u> , to <u>12/28 1961</u> , that (I) (we) last saw the deceased alive on <u>12/28 1961</u> , and that death occurred at <u>12:20 P.M.</u> from the causes and on the date stated above.											
<b>22a. SIGNATURE</b> <u>Lionel McHenry Hagg, M.D.</u>		<b>22b. DATE SIGNED</b> <u>12/28/61</u>									
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Lionel McHenry Hagg, M.D.</u>		<b>22d. ADDRESS</b> <u>Crownsville State Hospital, Maryland</u>									
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>1-2-62</u>									
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Mt. Calvary Em. &amp; A. Co.</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Ind.</u>									
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Rayner Sanders</u>		<b>25a. REC'D BY REGISTRAR</b> <u>1/4 '62</u>									
<b>25b. REGISTRAR'S SIGNATURE</b> <u>C. S. Hume</u>		<b>25c. DATE</b> <u>JAN 4 '62</u>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13473

13453

1 PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived) If institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore City</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Crownsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Crownsville State Hospital</i>		d. STREET ADDRESS <i>1618 W. Fayette St</i>	
3. NAME OF DECEASED (Type or print) First <i>Ellen</i> Middle <i>Smith</i> Last <i>Smith</i>		4. DATE OF DEATH Month <i>12</i> Day <i>29</i> Year <i>1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-27-92</i>
9. AGE (In years last birthday) <i>69</i> yrs		IF UNDER 1 YEAR Months <i>12</i> Days <i>29</i>	IF UNDER 24 HRS Hours <i>12</i> Min <i>4</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>American</i>	
13. FATHER'S NAME <i>John A. Carter</i>		14. MOTHER'S MAIDEN NAME <i>Emma E. Carter</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Andrew Williams - 300 Sellers Pt. Rd.</i>		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>acute heart failure</i> DUE TO (b) <i>myocardial infarction</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (it) (this hospital) attended the deceased from <i>4-30-1961</i> to <i>12-29-1961</i> , that (it) (we) last saw the deceased alive on <i>12-29-1961</i> , and that death occurred at <i>12-29-1961</i> M, from the causes and on the date stated above			
22a. SIGNATURE <i>Edison W. Pope</i> M.D.		22b. DATE SIGNED <i>12-30-61</i>	
22c. PHYSICIAN'S NAME (Type) <i>Crownsville State Hospital</i>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1-2-62</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Calvary</i>		23d. LOCATION (City, town, or county) (State) <i>A.A. Co., Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Charles R. Law - 802 Madison Ave.</i>		25a. REC'D BY REGISTRAR <i>JAN 4 '62</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles S. Kline</i>			

MEDICAL CERTIFICATION



## CERTIFICATE OF DEATH

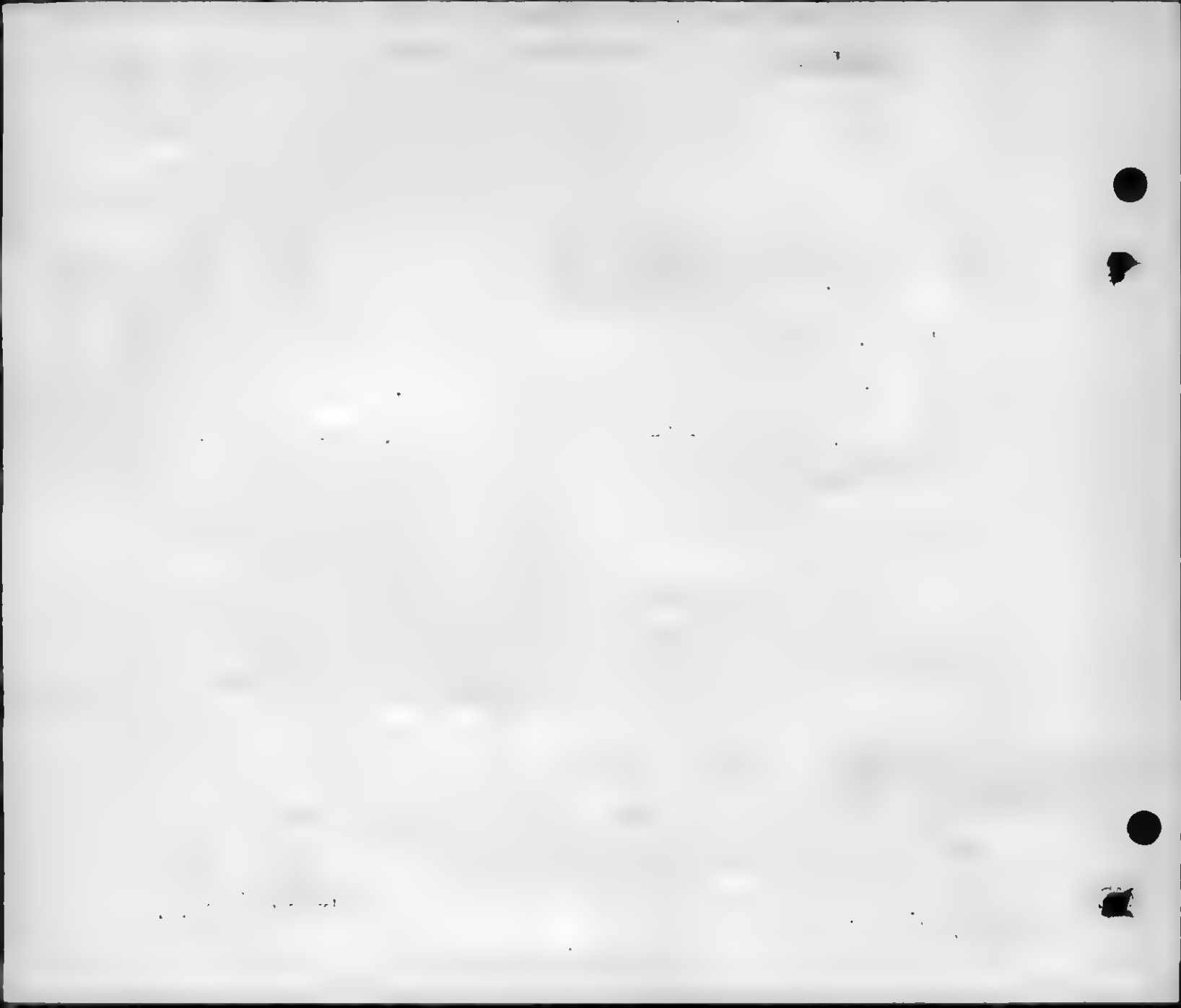
Reg. Dist. No. 18454

13474

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EDGEWATER				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WOODLAND BEACH				d. STREET ADDRESS WOODLAND BEACH			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Edgar R. Smith				4. DATE OF DEATH Dec. 6 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 8, 1884	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Stat. engineer				10b. KIND OF BUSINESS OR INDUSTRY Hotel		11. BIRTHPLACE (State or foreign country) Egg Harbor, N.J.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Humphrey Smith				14. MOTHER'S MAIDEN NAME Purdy P. Perry			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes ?				16. SOCIAL SECURITY NO. 150-07-8277		17. INFORMANT Mrs Elizabeth L. Buck- Daughter- same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Acute coronary thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardio-vascular disease (c) disease INTERVAL BETWEEN ONSET AND DEATH 7 hours							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 22, 1961, to Dec 5th, 1961, that I last saw the deceased alive on Dec 6, 1961, and that death occurred at 7:25 A.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE Sylvia M. Lim M.D.				Rt 1 Box 207-M 12/6/61			
PHYSICIAN'S NAME (Type) Sylvia M. Lim				Edgewater, Md.			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 8, 1961		22c. NAME OF CEMETERY OR CREMATORY Asbury M.E. Cemetery		22d. LOCATION (City, town, or county) (State) Sommers Point, N.J.	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home				ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR DATE DEC 8 '61	
						24b. REGISTRAR'S SIGNATURE S. K. K.	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

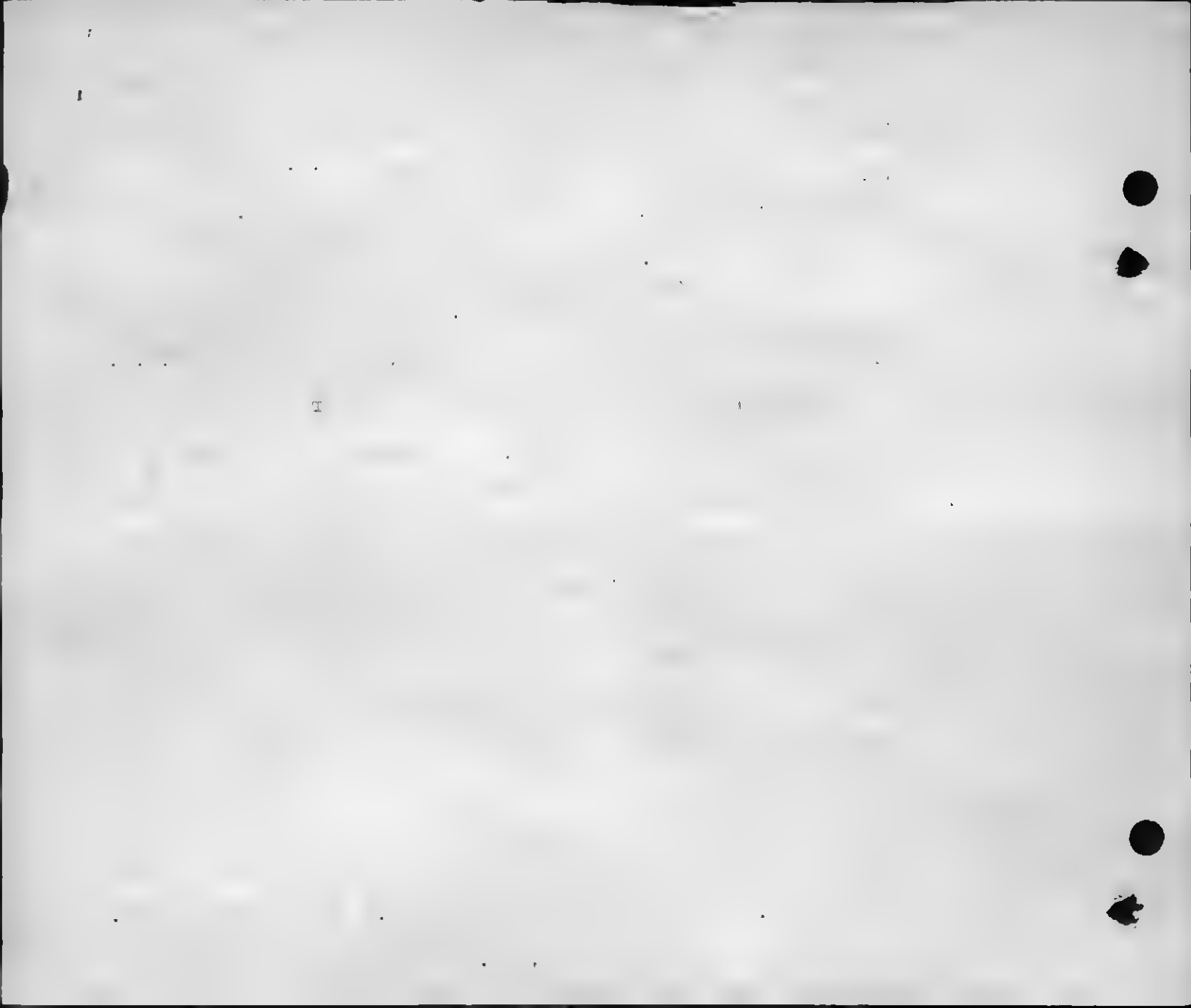
VR A15 (4)  
15M 9/60

13436

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13416

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN TB <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u> (P.O. Box #21) d. STREET ADDRESS <u>Old Annapolis Blvd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>EMMA E. MOHREIN</u>		<b>4. DATE OF DEATH</b> Month <u>DEC</u> Day <u>23</u> Year <u>1961</u>			
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
<b>8. DATE OF BIRTH</b> <u>13th Feb. 1914</u>		<b>9. AGE</b> (In years last birthday) <u>47</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housework</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own Home</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Brooklyn, New York</u>	
<b>13. FATHER'S NAME</b> <u>Joseph Herrmann</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Miller</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>131 05 8353</u>		<b>17. INFORMANT</b> <u>Mr. Charles Mohrein</u> Address <u>Same As # 2</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>420.0</u> DUE TO (b) <u>CORONARY THROMBOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>ARTERIOSCLEROTIC HEART DISEASE</u>		<b>19. INTERVAL BETWEEN ONSET AND DEATH</b> <u>IMMEDIATE</u> <u>4-8 HOURS</u> <u>UNKNOWN</u>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b> <u>Pasadena</u>		<b>(County)</b> <u>MARYLAND</u>		<b>(State)</b> <u>MARYLAND</u>	
<b>21. I certify that (I) (the hospital) attended the deceased from <u>DEC 21, 1961</u>, to <u>DEC 21, 1961</u>, that (I) (we) last saw the deceased alive on <u>DEC 21, 1961</u>, and that death occurred at <u>9:35 A.M.</u> from the causes and on the date stated above.</b>					
<b>22a. SIGNATURE</b> <u>Arthur Lankford Jr.</u>		<b>22b. DATE SIGNED</b> <u>12-23-61</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>ARTHUR LANKFORD JR.</u>	
<b>22d. ADDRESS</b> <u>PASADENA, MARYLAND</u>		<b>22e. ATTENDING PHYS.</b> <input checked="" type="checkbox"/> M.D. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>27th Dec. 1961</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Glen Haven Memorial Pk.</u>	
<b>23d. LOCATION</b> (City, town or county) <u>Glen Burnie, Md.</u>		<b>(State)</b> <u>Md.</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>[Signature]</u>		<b>25a. REC'D BY REGISTRAR</b> <u>DATE DEC 28 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>	



hours after  
The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13475

CERTIFICATE OF DEATH

13455

1. PLACE OF DEATH  
a. COUNTY ANNE ARUNDEL MARYLAND  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CROWNSVILLE  
c. LENGTH OF STAY IN TB 6 MO  
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CROWNSVILLE STATE HOSP

2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)  
a. STATE MARYLAND  
b. COUNTY BALTIMORE  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE  
d. STREET ADDRESS 712 CARROLLTON

3. NAME OF DECEASED (Type or print) EVA COOKE SMITH

4. DATE OF DEATH 12 26 1961

5. SEX FEMALE 6. COLOR OR RACE C 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH 10-28-18 9. AGE (In years last birthday) 43 yrs. 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE 11. BIRTHPLACE (County & State, or foreign country) VIRGINIA 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME SAMUEL COOKE 14. MOTHER'S MAIDEN NAME LAURA SMITH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO 16. SOCIAL SECURITY NO. HOSPITAL RECORDS 17. INFORMANT Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA  
DUE TO (b) TOXEMIA  
DUE TO (c) GENERALIZED SKIN ULCERS  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19  
20d. INJURY OCCURRED While at work ☐ Not While at work ☐  
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10-16-1961 to 12-26-1961 that (I) (we) last saw the deceased alive on 12-26-1961 and that death occurred at 5:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE John J. McGee M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ 22b. DATE SIGNED  
22c. PHYSICIAN'S NAME (Type) John J. McGee 22d. ADDRESS Crownsville Hospital

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 30 Dec 1961 23c. NAME OF CEMETERY OR CREMATORY Balto. Nat'l Cem 23d. LOCATION (City, town or county) (State) Baltimore Md

24. FUNERAL DIRECTOR'S SIGNATURE Wesley L. Sullivan ADDRESS 1011 ARLINGTON AVE 25a. REC'D BY REGISTRAR DEC 29 '61 25b. REGISTRAR'S SIGNATURE Arthur L. Thomas

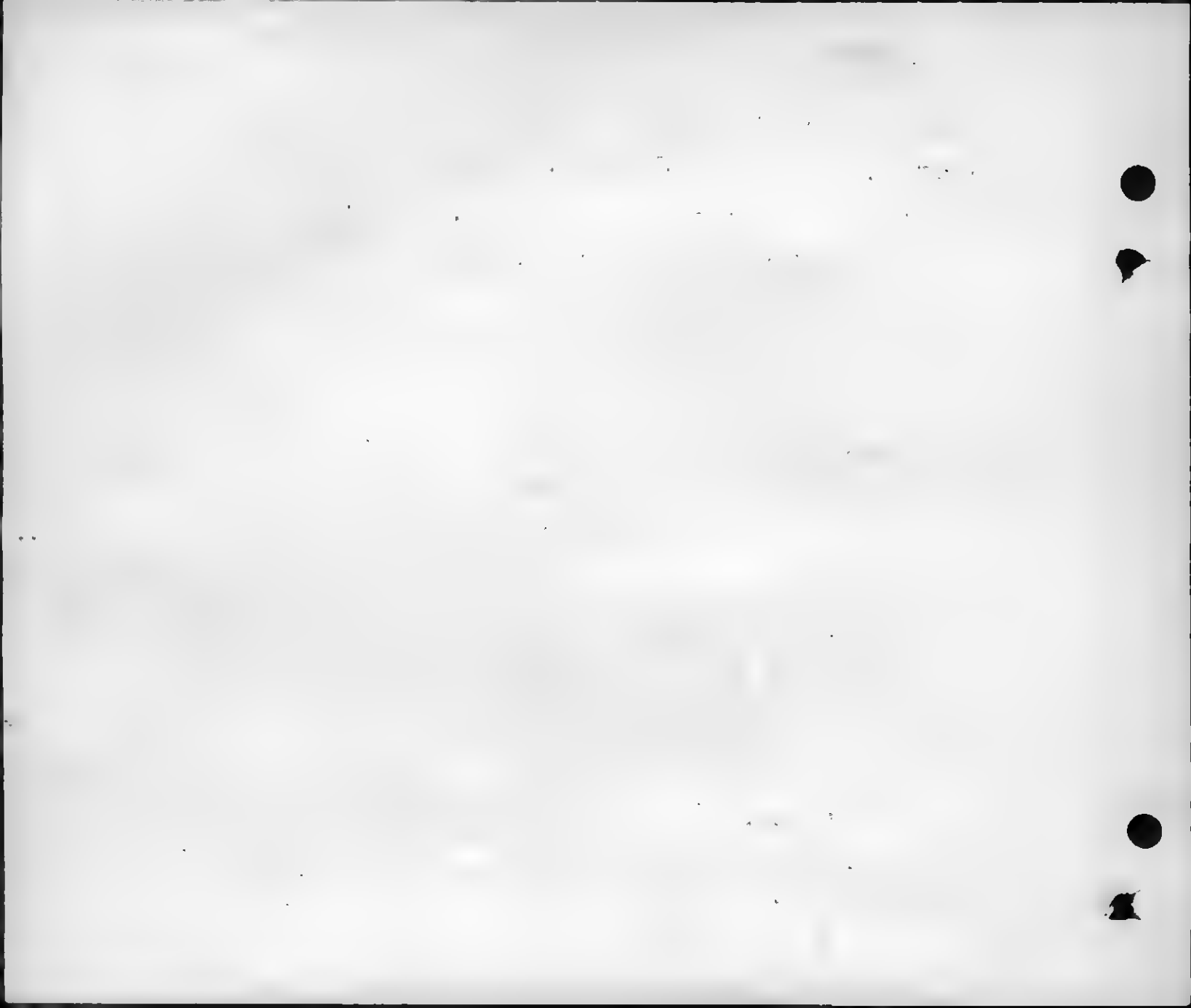


TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO VITAL STATISTICS: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then place removed carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

13476  
1  
13456  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownville Md</b> c. LENGTH OF STAY IN 1b <b>6 y, 10 mo, 7 d.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>3211-4</b> d. STREET ADDRESS <b>430 E. Lanvale Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Junius Edward Smith</b>		4. DATE OF DEATH Month Day Year <b>12 25 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>1892</b>
9. AGE (In years) (Type birthday) <b>69</b> yrs		10. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unemployed</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>unknown</b>		14. MOTHER'S MAIDEN NAME <b>Fannie Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO <b>unknown</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>412.1</b> DUE TO <b>Congestive Heart Failure</b> Conditions: if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Psychomotor Epilepsy</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>over 5 ye.,</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2/18</b> 19 <b>55</b> to <b>12/25</b> 19 <b>61</b> that (I) (we) last saw the deceased alive on <b>12/25</b> 19 <b>61</b> , and that death occurred at <b>3:50 am</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Hilda Reismann</b>		22b. DATE SIGNED <b>12/26/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Hilda Reismann</b>		22d. ADDRESS <b>Crownsville State Hospital</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/29/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>A.A. County Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Walter E. Elickson</b>		25a. REC'D BY REGISTRAR <b>DEC 28 '61</b>	
ADDRESS <b>1129 N. Caroline St.</b>		25b. REGISTRAR'S SIGNATURE <b>W. L. Hines</b>	



1  
FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, give the date and time of delay in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
FURNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

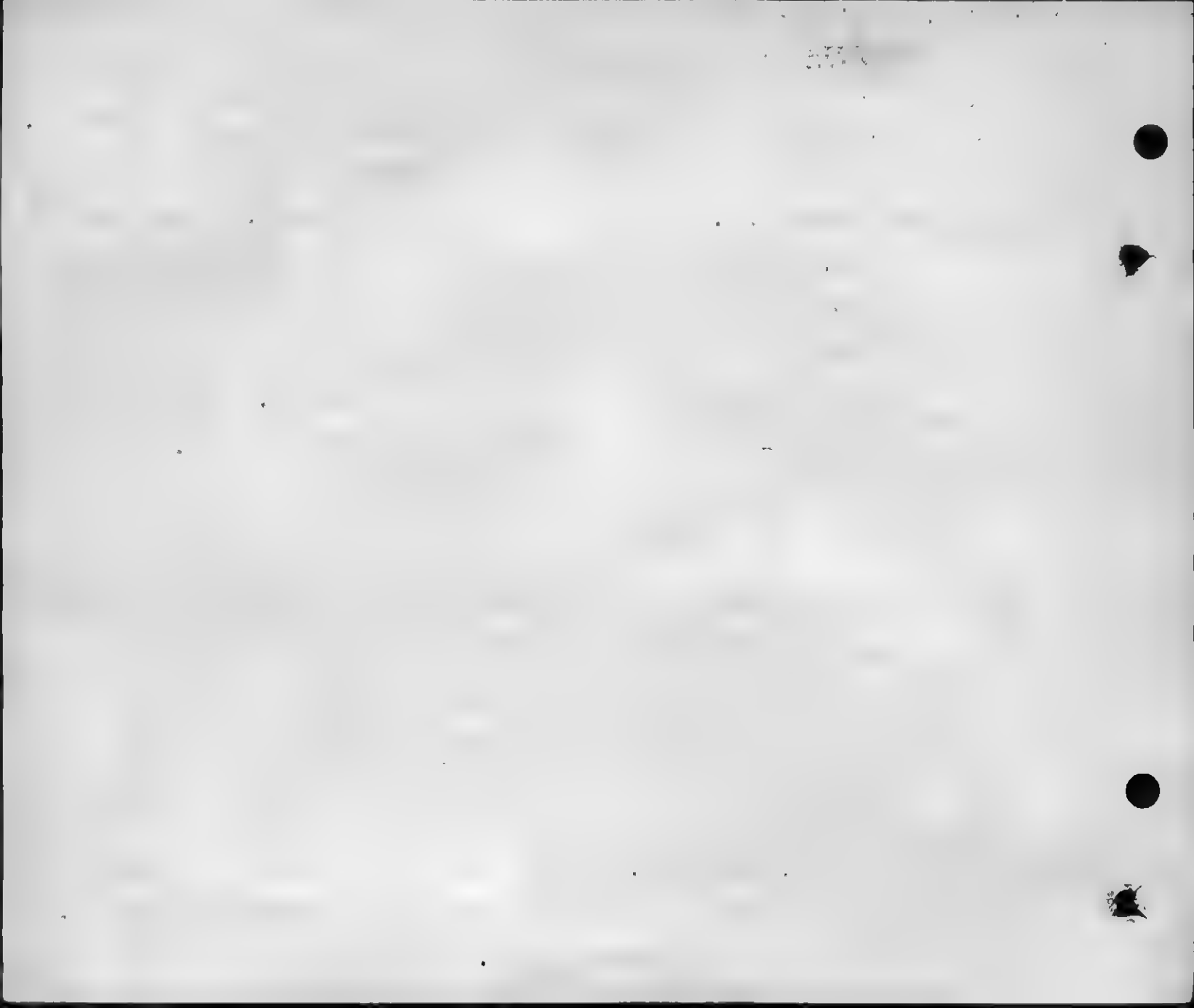
Item 18 Film 305  
1-12-62  
13477  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
Item 6 Film G304 1/2/62 1wk  
13457

1. PLACE OF DEATH  
a. COUNTY Anne Arundel County MARYLAND  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN b. 10  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 306 Chester, N. E. d. STREET ADDRESS 306 Chester, N. E.  
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)  
a. STATE Maryland b. COUNTY Anne Arundel Co.  
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis d. STREET ADDRESS 306 Chester, N. E.  
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) LEROY SYLVESTER STANLEY  
4. DATE OF DEATH December 6, 1961  
5. SEX Male 6. COLOR OR RACE Negro 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH June 8, 1919  
9. AGE (In years last birthday) 42 yrs. 10. IF UNDER 1 YEAR: Months 42 Days 0 Hours 0 Min. 0  
11. BIRTHPLACE (State or foreign country) Dorchester County, Md. 12. CITIZEN OF WHAT COUNTRY? USA

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 10b. KIND OF BUSINESS OR INDUSTRY Laborer  
13. FATHER'S NAME George Stanley 14. MOTHER'S MAIDEN NAME Lillie M. Camper  
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. ----- 17. INFORMANT Ruth Bailey, Cambridge, Md.  
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a). Massive Hemorrhage from the Lungs  
002X DUE TO (b) Pulmonary tuberculosis  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) Cachexia  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Part II  
19. WAS AUTOPSY PERFORMED? ☒ YES ☐ NO  
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. Cachexia  
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  
20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 19 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) (County) (State)  
21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐  
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ DEPUTY MEDICAL EXAMINER ☐  
ACTUAL SIGNATURE Howard G. Shaub M.D. DATE SIGNED 12/7/61  
EXAMINER'S NAME (Type) HOWARD G. SHAUB, M. D. Address (Street, city, town, or county) Cambridge, Md.  
22a. BURIAL, CREMATION, REMOVAL (Specify) Rem-Burial 22b. DATE THEREOF 12/10/1961 22c. NAME OF CEMETERY OR CREMATORY Madison Cemetery 22d. LOCATION (City, town, or country) Dorchester County, Md.  
23. FUNERAL DIRECTOR Michael M. Sullivan ADDRESS Cambridge, Md. 24a. REC'D BY REGISTRAR DEC 11 '61 24b. REGISTRAR'S SIGNATURE C. Stuart S. Hanks



## CERTIFICATE OF DEATH

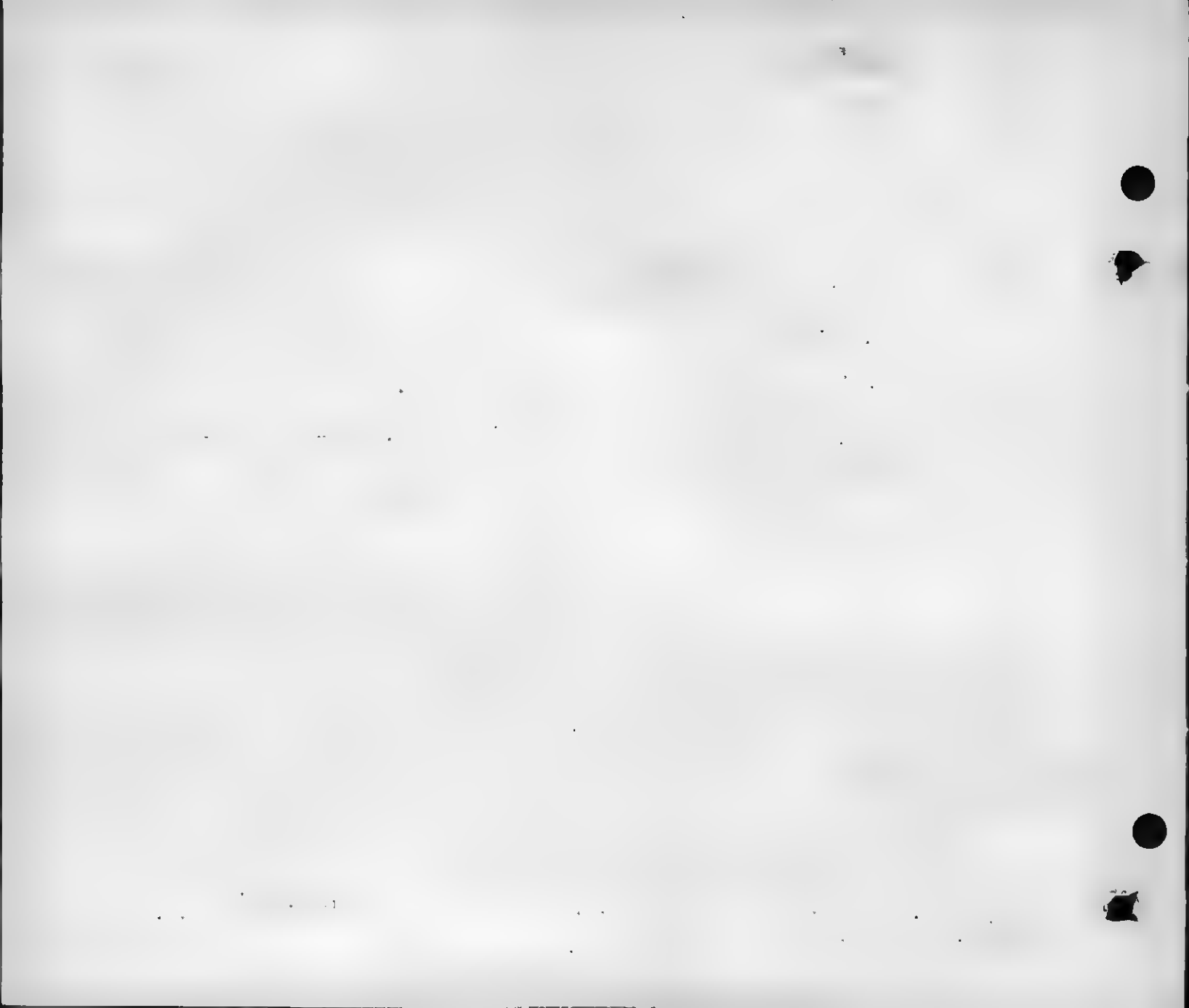
Reg. Dist. No. 18454

13474

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EDGEWATER				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EDGEWATER			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WOODLAND BEACH				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Edgar R. Smith				4. DATE OF DEATH Dec. 6 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 9, 1884	
9. AGE (In years last birthday) 76 yrs		IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS: Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Stat. engineer				10b. KIND OF BUSINESS OR INDUSTRY Hotel		11. BIRTHPLACE (State or foreign country) Egg Harbor, N.J.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Humphrey Smith				14. MOTHER'S MAIDEN NAME Purdy P. Perry			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes ?				16. SOCIAL SECURITY NO 150-07-8277		17. INFORMANT Mrs Elizabeth L. Buck- Daughter- same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH 7 hours
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute coronary thrombosis							
420.1 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardio-vascular disease							3 years
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 22, 1961 to Dec 5th, 1961 that I last saw the deceased alive on Dec 6, 1961 and that death occurred at 7:25 A.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Sylvia M. Lim M.D.				Rt. 1 Box 207-M 12/6/61			
PHYSICIAN'S NAME (Type) Sylvia M. Lim, Edgewater, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 8, 1961		22c. NAME OF CEMETERY OR CREMATORY Asbury M.E. Cemetery		22d. LOCATION (City, town, or county) (State) Sommers Point, N.J.	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home				ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR DATE Dec 8 '61	
				24b. REGISTRAR'S SIGNATURE J. E. Hume			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

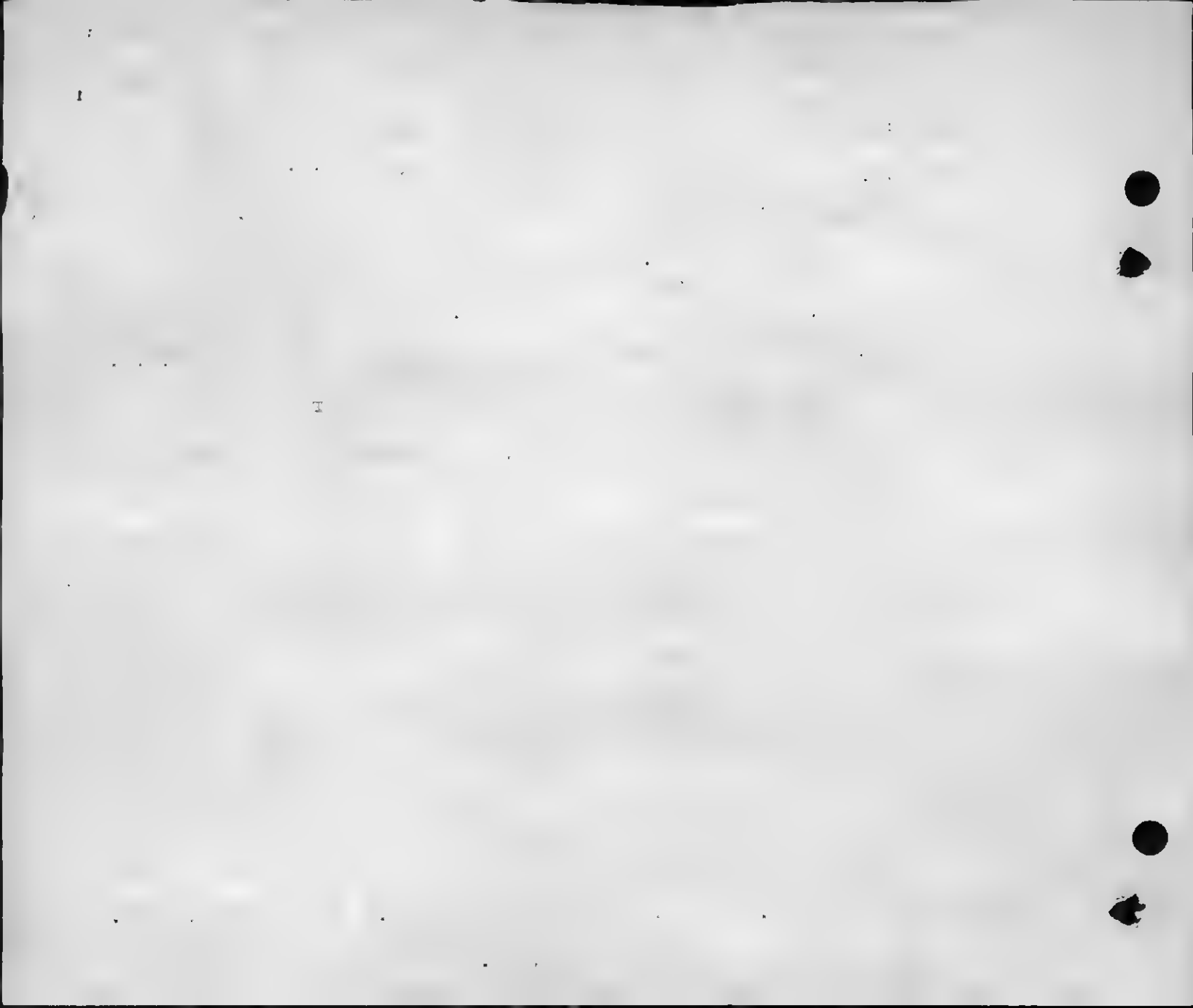


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. The law requires that the death certificate be completed within 24 hours after death. The law requires that the death certificate be completed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY IN TOWN <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Anne Arundel General Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Pasadena (P.O. Box #21)</b> d. STREET ADDRESS <b>Old Annapolis Blvd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																											
3. NAME OF DECEASED (Type or print) <b>EMMA E. MOHREIN</b>		4. DATE OF DEATH <b>DEC 23 1961</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <b>13th Feb. 1914</b>		9. AGE (In years last birthday) <b>47</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.																	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Brooklyn, New York</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>																			
13. FATHER'S NAME <b>Joseph Herrmann</b>				14. MOTHER'S MAIDEN NAME <b>Mary Miller</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>131 05 8353</b>				17. INFORMANT <b>Mr. Charles Mohrein</b> Address <b>Same As # 2</b>															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>CORONARY THROMBOSIS</b> (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>UNKNOWN</b>												INTERVAL BETWEEN ONSET AND DEATH <b>48 HOURS</b>																			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO												20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>9:35 AM</b>				20c. TIME OF INJURY Month, Day, Year <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>PASADENA, MARYLAND</b>				20f. (City or town) (County) (State)			
21. I certify that (I) (the hospital) attended the deceased from <b>DEC 21 1961</b> to <b>DEC 21 1961</b> , that (I) (we) last saw the deceased alive on <b>DEC 21 1961</b> and that death occurred at <b>9:35 AM</b> from the causes and on the date stated above.												22a. SIGNATURE <b>Arthur Lankford Jr.</b>				22b. DATE SIGNED <b>12-23-61</b>				22c. PHYSICIAN'S NAME (Type) <b>ARTHUR LANKFORD, JR.</b>				22d. ADDRESS <b>PASADENA, MARYLAND</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>27th Dec. 1961</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memorial Pk.</b>				23d. LOCATION (City, town or county) (State) <b>Glen Burnie, Md.</b>																			
24. FUNERAL DIRECTOR'S SIGNATURE <b>A. K. Long</b>				25a. REC'D BY REGISTRAR <b>DEC 28 '61</b>				25b. REGISTRAR'S SIGNATURE <b>1-2-7-2-61</b>				25c. REGISTRAR'S NAME <b>1-2-7-2-61</b>																			



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13475

## CERTIFICATE OF DEATH

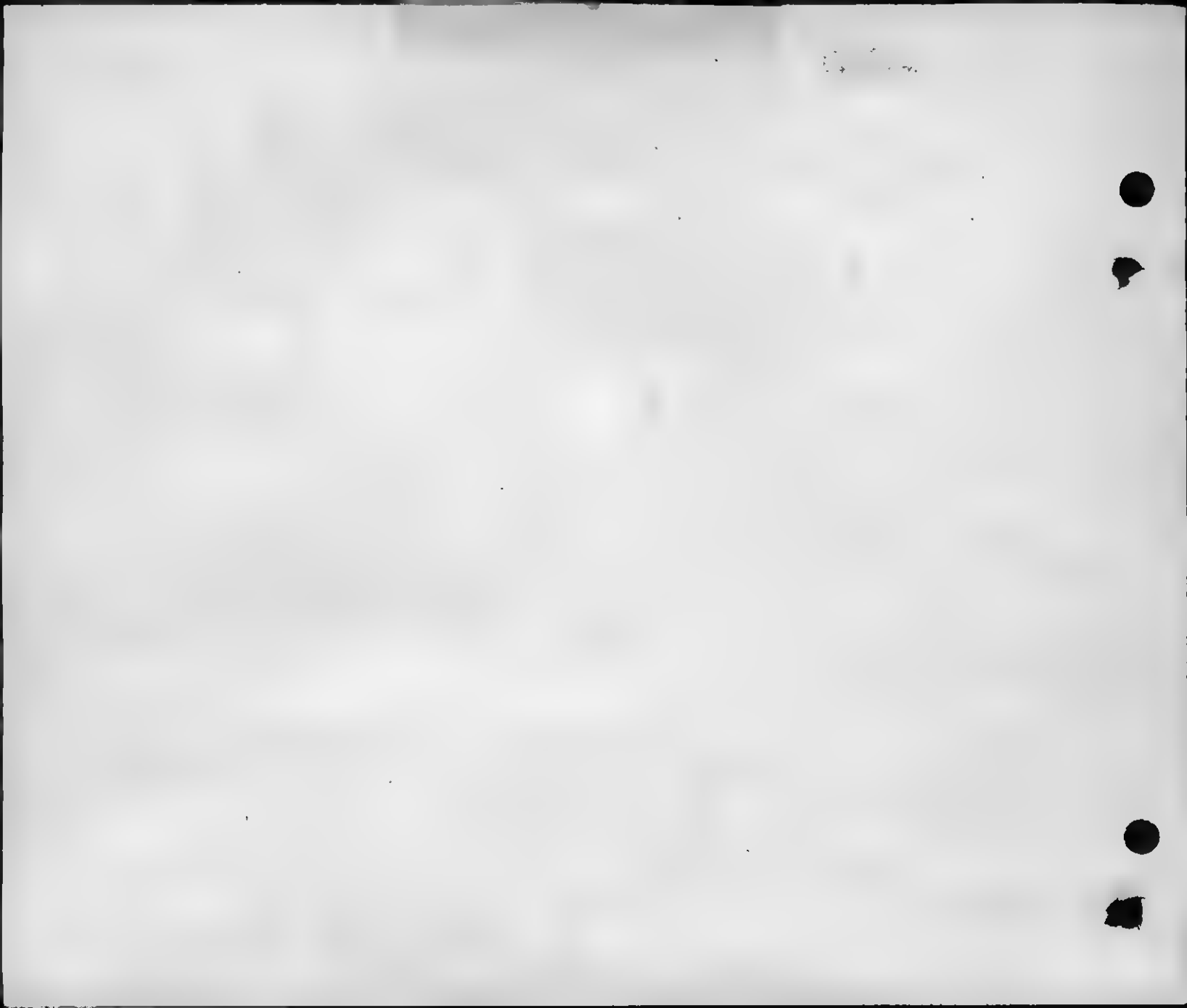
13455

Item 9 Film 6300 2/5/62 ink

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CROWNSVILLE</u> c. LENGTH OF STAY IN b. <u>6 MO</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>CROWNSVILLE STATE HOSP</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> d. STREET ADDRESS <u>712 CARROLLTON</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>EUA COOKE SMITH</u>		4. DATE OF DEATH <u>12 26 1961</u>		5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-28-18</u>		9. AGE (In years last birthday) <u>43</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>VIRGINIA</u>				11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>SAMUEL COOKE</u>				14. MOTHER'S MAIDEN NAME <u>LAURA SMITH</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>HOSPITAL RECORDS</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> <u>715X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>TOXEMIA</u> (c) <u>GENERALIZED SKIN ULCERS</u> causing the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>10-16</u> 19 <u>61</u> , to <u>12-26</u> 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>12-26</u> 19 <u>61</u> , and that death occurred at <u>5:30</u> A.M. from the causes and on the date stated above.															
22a. SIGNATURE <u>John J. McGee</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type) <u>J. M'GEE</u>				22d. ADDRESS <u>CROWNSVILLE HOSPITAL</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>30 Dec 1961</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Balto. Nat'l Cem</u>				23d. LOCATION (City, town or county) (State) <u>Baltimore Md</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>WESLEY L. SULLIVAN</u>				ADDRESS <u>1011 ARLINGTON AVE</u>				25a. REC'D BY REGISTRAR <u>DEC 29 '61</u>				25b. REGISTRAR'S SIGNATURE <u>Carlton S. Hanna</u>			

MEDICAL CERTIFICATION

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. Page 4  
may be refiled by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

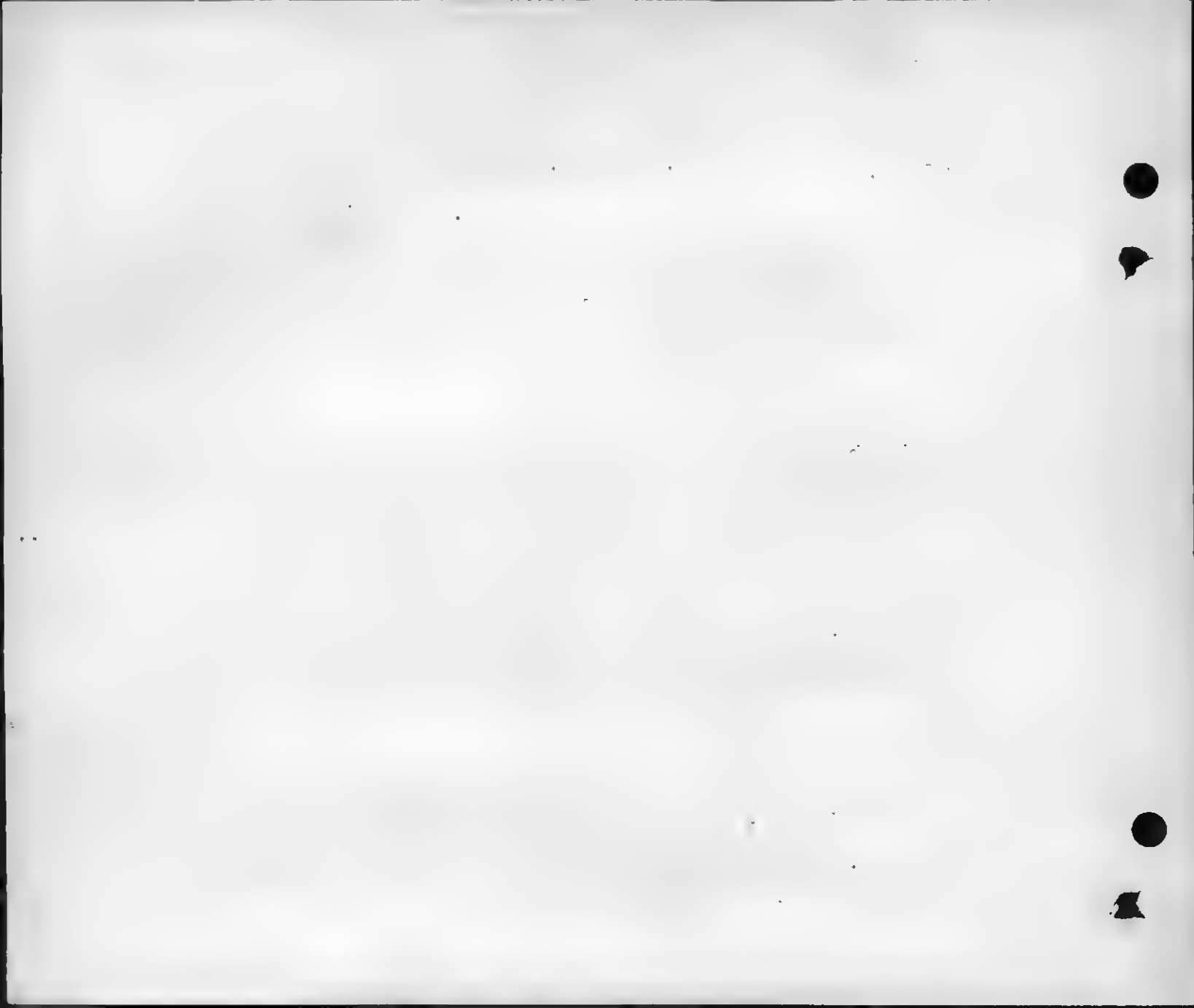
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15M 9/59

13476

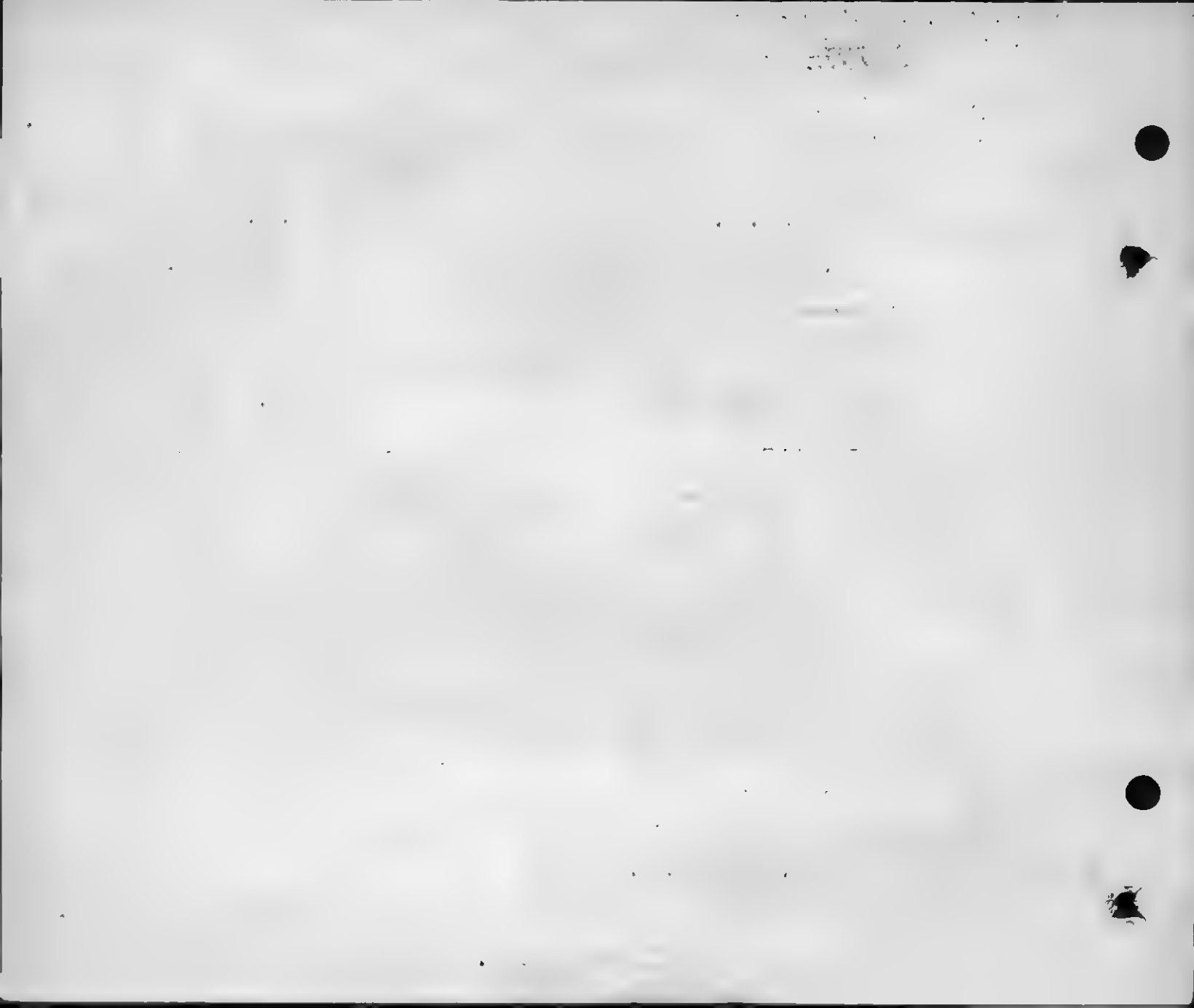
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13456

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownville Md</b> c. LENGTH OF STAY IN lb <b>6 y, 10 mo, 7 d.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>3VA1-4</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>430 E. Lanvale Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Junius Edward Smith</b>		4. DATE OF DEATH Month <b>12</b> Day <b>25</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>1892</b>
9. AGE (In years last birthday) <b>69</b>		10. IF UNDER 1 YEAR Months <b>12</b> Days <b>25</b> Hours <b>19</b> Min <b>61</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unemployed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>unknown</b>		14. MOTHER'S MAIDEN NAME <b>Fannie Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO Congestive Heart Failure Conditions: if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Psychomotor Epilepsy</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>over 5 ye.,</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2/18</b> 19 <b>55</b> to <b>12/25</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>12/25</b> 19 <b>61</b> , and that death occurred at <b>3:50 AM</b> from the causes and on the date stated above			
22a. SIGNATURE <b>Hilda Reismann</b> 22c. PHYSICIAN'S NAME (Type) <b>Dr. Hilda Reismann</b>		22b. ADDRESS <b>Crownsville State Hospital</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/29/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>A.A. County, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>William E. Eichten</b> ADDRESS <b>1129 N. Caroline St.</b>		25a. REC'D BY REGISTRAR <b>DEC 28 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>William E. Eichten</b>		25c. DATE <b>DEC 28 '61</b>	







## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13478

## CERTIFICATE OF DEATH

Reg. Dist. No. 13458

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>143 Spa Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>VIOLA</b> Middle <b>W</b> Last <b>STEHLE</b>		4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>17</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 16, 1880</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Annapolis, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Williams</b>		14. MOTHER'S MAIDEN NAME <b>Jessie HETZEL</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO <b>219-16-1383</b>	
17. INFORMANT <b>Mrs. Jeannet S. Irons- Daughter- Arnold, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b> <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH. <b>1 WEEK</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>12-17</b> , 19 <b>61</b> , to <b>12-17</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>12-17</b> , 19 <b>61</b> , and that death occurred at <b>930P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>73 Franklin Street, Annapolis, Maryland</b> DATE SIGNED <b>12/18/61</b> ACTUAL SIGNATURE <b>Edward S. Beck</b> M.D. PHYSICIAN'S NAME (Type) <b>Edward S. Beck</b> <b>73 Franklin Street, Annapolis, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Dec. 20, 1961</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Annapolis, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b> ADDRESS <b>Annapolis, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 22 '61</b>	24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. It may be retained in the hospital or attending physician's office for a period of 30 days after the death. After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL - ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 must be completed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

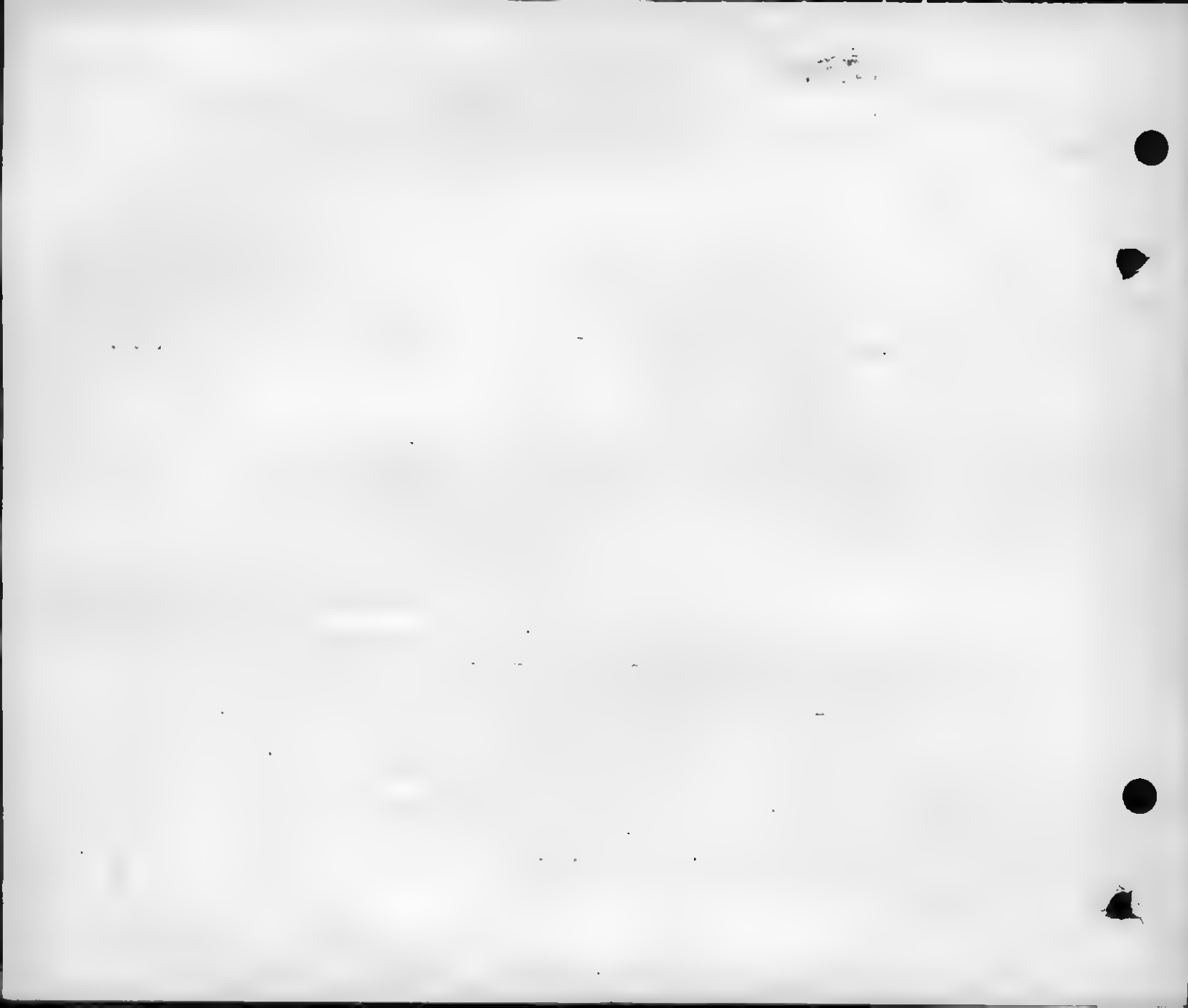
13479

13

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Maryland</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>						c. LENGTH OF STAY IN It <u>1</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>						d. STREET ADDRESS <u>103 Northwest St.</u>					
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> (ELIZAH) Middle <u>STEVENS</u> Last <u>STEVENS</u>						4. DATE OF DEATH Month <u>December</u> Day <u>26</u> Year <u>1961</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-1-1891</u>		9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Settled</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>Settled</u>					
11. BIRTHPLACE (County & State or foreign country) <u>Maryland</u>						12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					
13. FATHER'S NAME <u>George Stevens</u>						14. MOTHER'S MAIDEN NAME <u>Mary Snowden</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) <u>No</u>						16. SOCIAL SECURITY NO <u>331X</u>					
17. INFORMANT <u>Katherine Murray - Annapolis, Md.</u>						Address <u>St. Margaret's, Md.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Artery + Pneumonia</u>											
331X DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Heart Disease, chronic</u>											
DUE TO (c) <u>Coronary vascular accident</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour <u>19</u> a.m. <u>3:45</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				20g. (County)				20h. (State)			
21. I certify that (I) (Physician) attended the deceased from <u>Dec. 11, 1961</u> to <u>Dec. 25, 1961</u> , that (I) (witness) saw the deceased alive on <u>Dec. 25, 1961</u> , and that death occurred at <u>3:45 AM</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>A. T. Allen</u>						22b. DATE SIGNED <u>Dec. 26, 1961</u>					
22c. PHYSICIAN'S NAME (Type) <u>A T ALLEN</u>						22d. ADDRESS <u>62 Cathedral St., Annapolis, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL, (Specify) <u>Burial</u>				23b. DATE THEREOF <u>12-29-61</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Broadneck</u>			
23d. LOCATION (City, town or county) <u>St. Margaret's, Md.</u>				23e. (State) <u>Md.</u>				23f. (County)			
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Geese, D. Anna, Md.</u>						25a. REC'D BY REGISTRAR <u>DEC 26 '61</u>					
25b. REGISTRAR'S SIGNATURE <u>William L. Hanna</u>						25c. (State)					

25-1

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. HOSPITAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Queen Ann</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>6 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chester</b>		d. STREET ADDRESS <b>Box 222</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>John E Stevenson</b>				4. DATE OF DEATH Month Day Year <b>12 4 1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 18, 1892</b>	
9. AGE (In years last birthday) <b>69</b>		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS Months Days Hours Min		12. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Oyster Worker &amp; Butler</b>		14. KIND OF BUSINESS OR INDUSTRY -----		15. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		16. FATHER'S NAME <b>John Stevenson</b>	
17. MOTHER'S MAIDEN NAME <b>Edith Sterling</b>		18. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		19. SOCIAL SECURITY NO <b>Unknown</b>		20. INFORMANT <b>Hospital Records</b>	
21. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Old Cerebro-vascular Accident</b> DUE TO (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c) <b>Generalized Arteriosclerosis</b>		22. INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>		23. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>		24. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
25a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		25b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----		26a. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		26b. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/>	
26c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		26d. (City or town) -----		26e. (County) -----		26f. (State) -----	
27. I certify that (I) (this hospital) attended the deceased from <b>11/28 1961</b> to <b>12/4 1961</b> , that (I) (we) last saw the deceased alive on <b>12/4 1961</b> , and that death occurred at <b>8:16 PM</b> , from the causes and on the date stated above							
28a. SIGNATURE <b>Lionel McHenry Mapp</b>				28b. M. D. <b>Lionel McHenry Mapp, M. D.</b>		28c. DATE <b>12/4/61</b>	
29a. PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M. D.</b>				29b. ADDRESS <b>Crownsville State Hospital, Maryland</b>			
30a. BURIAL CREMATION REMOVAL (Specify) <b>Removal</b>		30b. DATE THEREOF <b>12/7/61</b>		30c. NAME OF CEMETERY OR CREMATORY <b>Chester-Corn</b>		30d. LOCATION (City, town, or county) (State) <b>Chester Md</b>	
31. FUNERAL DIRECTOR'S SIGNATURE <b>James B. Reeves</b>				32. ADDRESS <b>Easton</b>		33. REC'D BY REGISTRAR DATE <b>DEC 7 '61</b>	
34. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>				35. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained in hospital or attending physician's office for 30 days. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13481

13461

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>(D.C.)</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>				c. LENGTH OF STAY IN 1b <b>7 mo. 9 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				d. STREET ADDRESS <b>6501 Ritchie Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Lincoln</b> Last <b>Stewart</b>				4. DATE OF DEATH Month <b>12</b> Day <b>13</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 25, 1874</b>	
9. AGE (In years last birthday) <b>87</b> yrs.		IF UNDER 1 YEAR Months <b>12</b> Days <b>13</b>		IF UNDER 24 HRS Hours <b>13</b> Min. <b>1961</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Prostate</b> DUE TO <b>177X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>-----</b> DUE TO <b>-----</b> (c) <b>-----</b>				INTERVAL BETWEEN ONSET AND DEATH <b>-----</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome Associated with Arteriosclerosis</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>-----</b> 19 <b>61</b> p. m. <b>-----</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>	
20f. (City or town) <b>-----</b>				(County) <b>-----</b>		(State) <b>-----</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>5/4</b> 19 <b>54</b> to <b>12/13</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>12/13</b> 19 <b>61</b> , and that death occurred at <b>7:10 P.</b> M., from the causes and on the date stated above.							
22a. SIGNATURE <b>Hildegard Heard Reissman</b>				M. D. <input checked="" type="checkbox"/> ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE <b>12/14/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Hildegard Heard Reissman, M. D.</b>				22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>12-2061</b>		23b. DATE THEREOF <b>12-2061</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Mem. Park Huntville</b>		23d. LOCATION (City, town, or county) (State) <b>M.D.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Malcolm Schey Inc</b>				ADDRESS <b>424 R St NW</b>		25a. REC'D BY REGISTRAR <b>DEC 26 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>-----</b>							

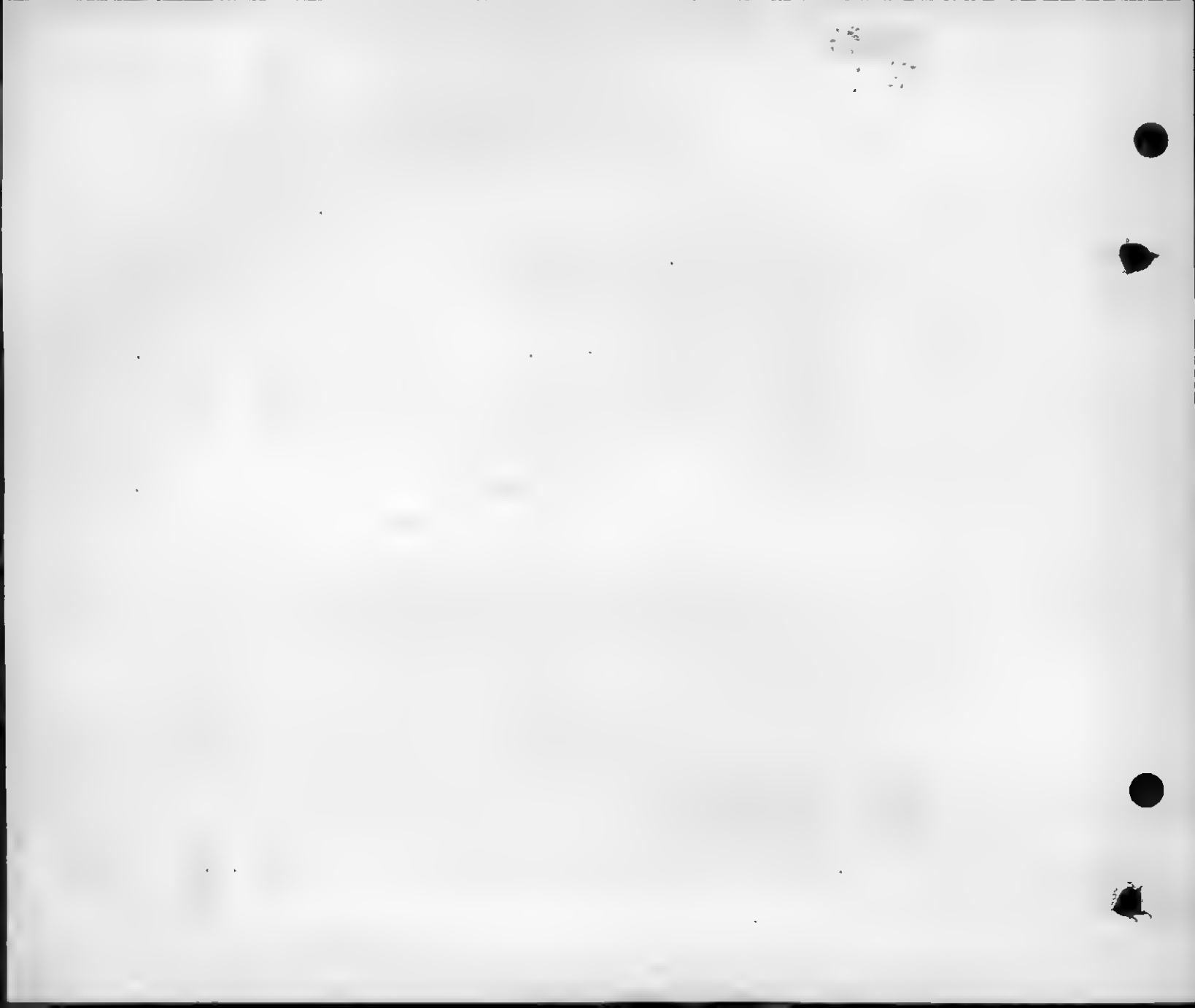


13482

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

13462

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel County</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>110 A - Street S.W. (Home)</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Walter M. Stinchcomb</b>				4. DATE OF DEATH Month Day Year <b>December 18 1961</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11 March 1974</b>		9. AGE (In years last birthday) <b>87</b> yrs	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Contractor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Contractor-Ret.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Alfred A. Stinchcomb</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Stinchcomb</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <b>Mr. Victor Stinchcomb 110 A- Street SW</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cardio-Vascular Disease</b> (c) INTERVAL BETWEEN ONSET AND DEATH <b>6 weeks</b> <b>2 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Glen Burnie</b>		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec 17</b> 19 <b>61</b> , to <b>Dec 18</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Dec 17</b> 19 <b>61</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above							
22a. SIGNATURE <b>James S. Billingslea</b>				22b. ADDRESS <b>108 Central Ave. N.W. Glen Burnie</b>		22c. DATE SIGNED <b>Dec. 20, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>James S. Billingslea</b>				22d. ADDRESS <b>108 Central Ave. N.W. Glen Burnie</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>21 Dec. 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Asbury Methodist</b>		23d. LOCATION (City, town, or county) (State) <b>Arnold Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping &amp; Kirkley Funeral Home</b>				25a. REC'D BY REGISTRAR DATE <b>DEC 27 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

VS A15 (4)  
15M 10/57

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13483

## CERTIFICATE OF DEATH

13463

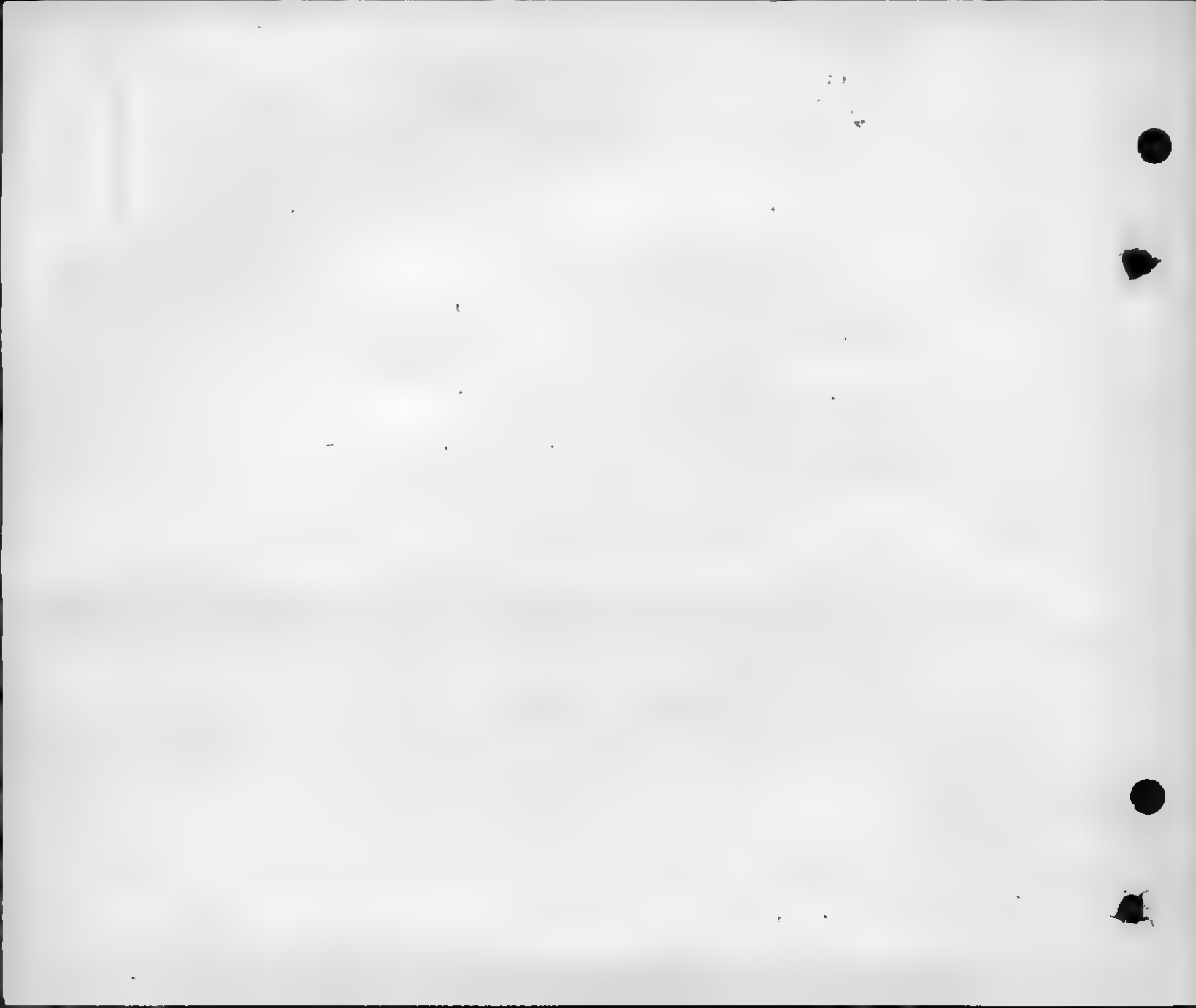
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brooklyn</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brooklyn</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>406 Hillcrest Ave.</b>		d. STREET ADDRESS <b>406 Hillcrest Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>DAISY</b> Middle <b>CROMWELL</b> Last <b>THOMPSON</b>		4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>20</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 19, 1882</b>
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months <b>79</b> Days <b>79</b> Hours <b>79</b> Min. <b>79</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Washington L. Slaughter</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mr. Henry M. Thompson - Husband - same as # 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO <b>Hypertensive Cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardiovascular disease</b> (c) <b>Hypertensive Cardiovascular disease</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 20, 1957</b> to <b>Dec. 20, 1961</b> , that I last saw the deceased alive on <b>12/19</b> , 19 <b>61</b> , and that death occurred at <b>6:45</b> AM, from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>201 Patapsco Ave. Brooklyn, Maryland</b> DATE SIGNED <b>Samuel Rubin</b>			
ACTUAL SIGNATURE <b>Samuel Rubin</b> M.D.		PHYSICIAN'S NAME (Type) <b>Sam Rubin M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 23, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Bluff Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b>		ADDRESS <b>Annapolis, Maryland</b>	
24a. REC'D BY REGISTRAR <b>DEC 26 '61</b>		24b. REGISTRAR'S SIGNATURE <b>William S. Hopper</b>	

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be filled within 72 hours after death. Page 4 must be retained by the hospital or attending physician.  
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and carefully filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 7, 61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
13484  
CERTIFICATE OF DEATH  
13464

1. PLACE OF DEATH a. COUNTY <u>AA.</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>AA.</u> b. COUNTY <u>AA.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fernside</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>AA.</u>	
c. LENGTH OF STAY IN 1b <u>20 yrs.</u>		d. STREET ADDRESS <u>238 Annapolis Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>238 Annapolis Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary Jane Linley</u>		4. DATE OF DEATH <u>Dec 21 1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 27 1874</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Deals Island Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME (unknown) <u>Webster</u>		14. MOTHER'S MAIDEN NAME <u>Cornelia White</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>James Webster Linley</u>		18. ADDRESS <u>Same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-vascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arterio-sclerosis</u> (c) <u>DUE TO</u> cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>2-3 hr</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/21/61</u> to <u>12/21/61</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>12/21/61</u> , 19 <u>61</u> , and that death occurred at <u>3 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Chas. L. Ball Jr.</u>		22b. DATE SIGNED <u>12/21/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Chas. L. Ball, Jr., M.D.</u>		22d. ADDRESS <u>Linthicum Hgts Md</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12-23-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street, ZONE 2</u>		25a. REC'D BY REGISTRAR <u>DEC 26 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>		25c. DATE	

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TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

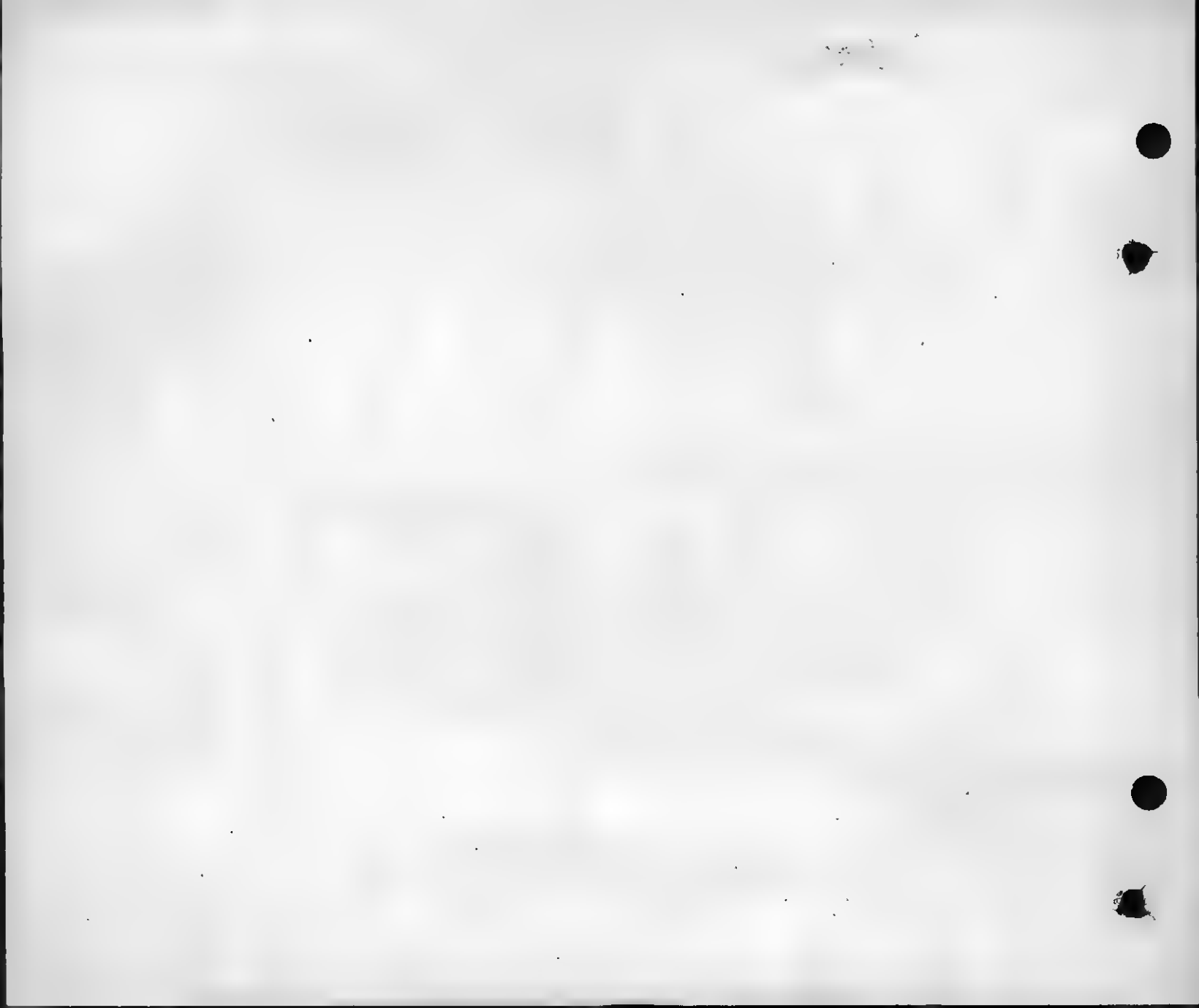
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

13485

13465

1. PLACE OF DEATH a. COUNTY <u>R. A.</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>C. C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>912 Smithfield St.</u>		d. STREET ADDRESS <u>912 Smithfield St.</u>	
NAME OF DECEASED (Type or print) <u>William D. Tongue</u>		4. DATE OF DEATH Month <u>12</u> Day <u>10</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-15-1901</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel Tongue</u>		14. MOTHER'S MAIDEN NAME <u>Sally Henson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Mary Downs Harwood M</u>	
17. INFORMANT <u>Mary Downs Harwood M</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Right</u>			
DUE TO <u>Suppurative Myocarditis</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
DUE TO (b) <u>2 yrs</u>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19, and that death occurred at M, from the causes and on the date stated above			
22a. SIGNATURE <u>R. H. Richardson</u>		22b. DATE SIGNED <u>12/11/61</u>	
22c. PHYSICIAN'S NAME (Print) <u>RICHARDSON M.D.</u>		22d. ADDRESS <u>110-CHERRY ST ANN</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-14-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Bronck Hill</u>		23d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Beesett</u>		25a. REC'D BY REGISTRAR <u>Anna M</u>	
ADDRESS <u>Anna M</u>		25b. REGISTRAR'S SIGNATURE <u>18 Thoms</u>	
DATE <u>12-13-61</u>			

MEDICAL CERTIFICATION



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13486

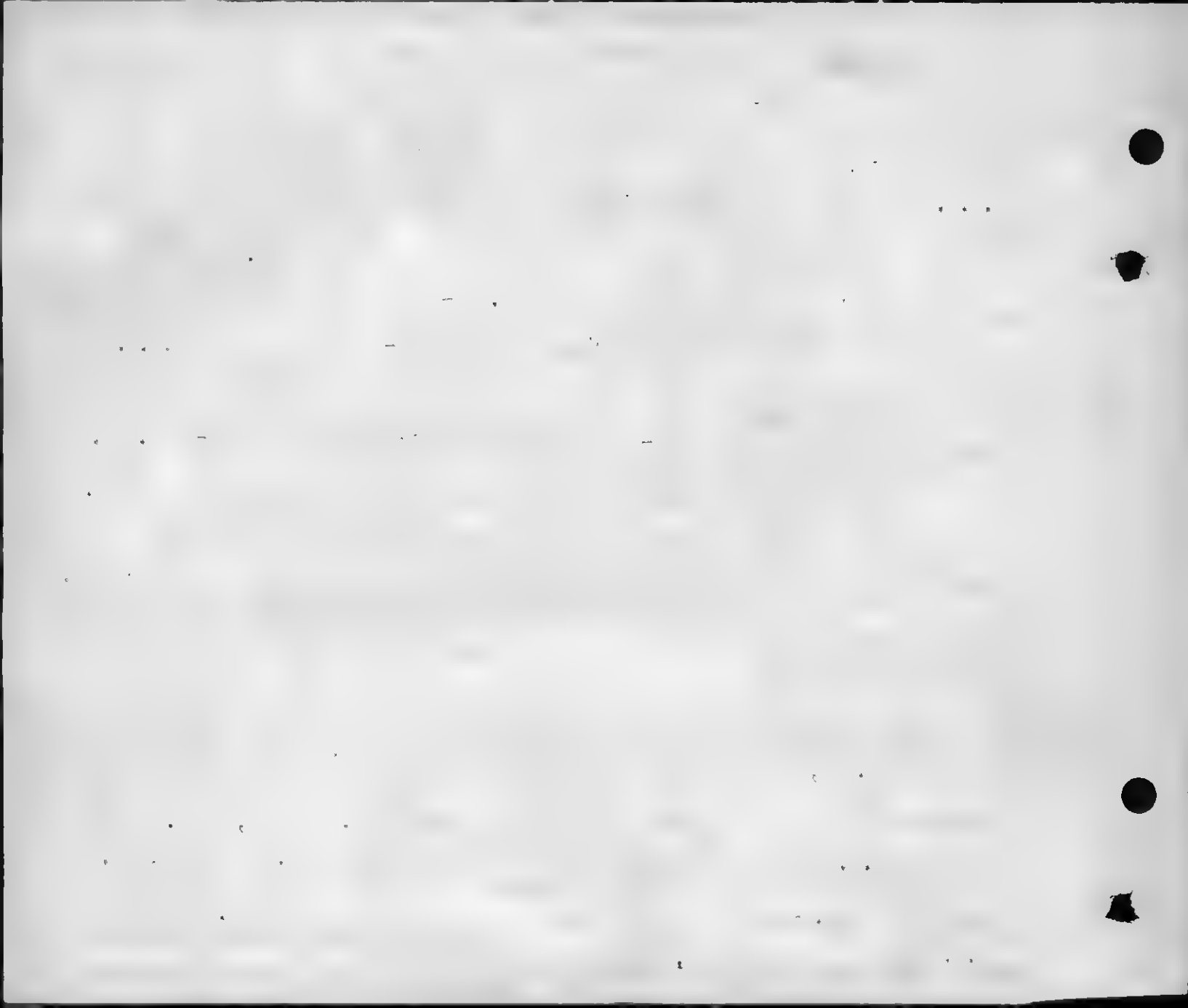
## CERTIFICATE OF DEATH

Reg. Dist. No. 13466

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis - 50 Fleet Street</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>// Annapolis</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>D.O.A. Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>50 Fleet Street</b>	
3. NAME OF DECEASED (Type or print) First <b>AMOS</b> Middle <b>TURNER</b> Last		4. DATE OF DEATH Month <b>Dec.</b> Day <b>3</b> Year <b>19 61</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 20- 1900</b>
9. AGE (In years last birthday) <b>61</b> yrs.		10. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shoe Maker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Shoe Repairing</b>	
11. BIRTHPLACE (State or foreign country) <b>Montecella- Florida</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Turner</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-05-0229</b>	
17. INFORMANT <b>Pauline Turner-106 South Street-Anna. Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Artery Disease</b> <b>420.1</b> DUE TO <b>Hypertensive Cardiovascular Disease and Diabetes Mellitus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b> <b>10 yrs.</b> <b>10 yrs.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a. n.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 7, 1960</b> , to <b>Dec. 3, 1961</b> , that I last saw the deceased alive on <b>Oct. 23, 1961</b> , and that death occurred at <b>M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Theodore H. Johnson, M. D.</b> DATE SIGNED ACTUAL SIGNATURE <b>Theodore H. Johnson, M.D.</b> PHYSICIAN'S NAME (Type) <b>T.H. Johnson</b> <b>37 Calvert St. Annapolis, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 8-61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Brewer Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C.E. HICKS III</b>		ADDRESS <b>Annapolis, Maryland</b>	
24a. REC'D BY REGISTRAR <b>DEC 13 '61</b>		24b. REGISTRAR'S SIGNATURE <b>C. E. Hicks</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



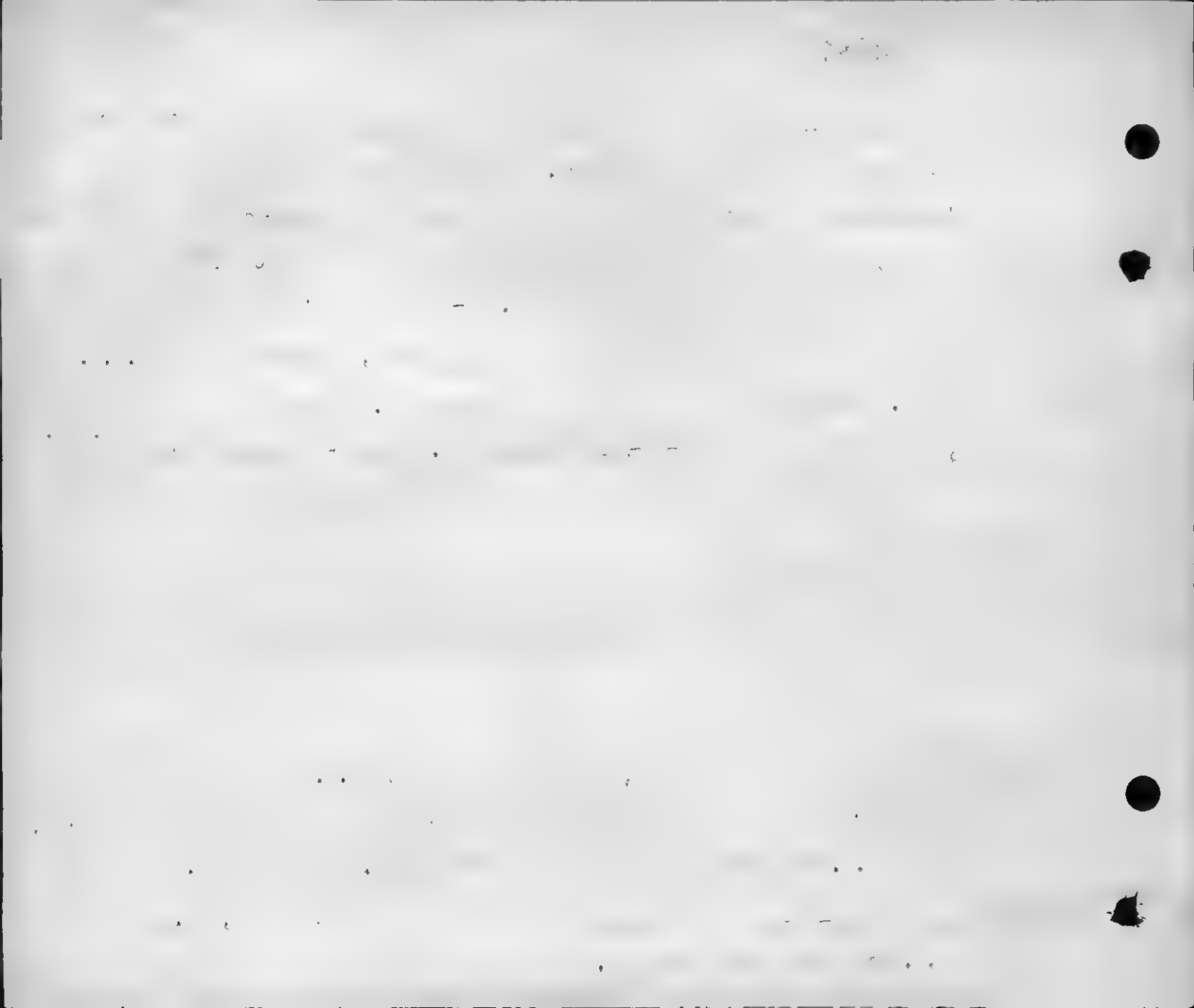
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. **FUNERAL DIRECTOR** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

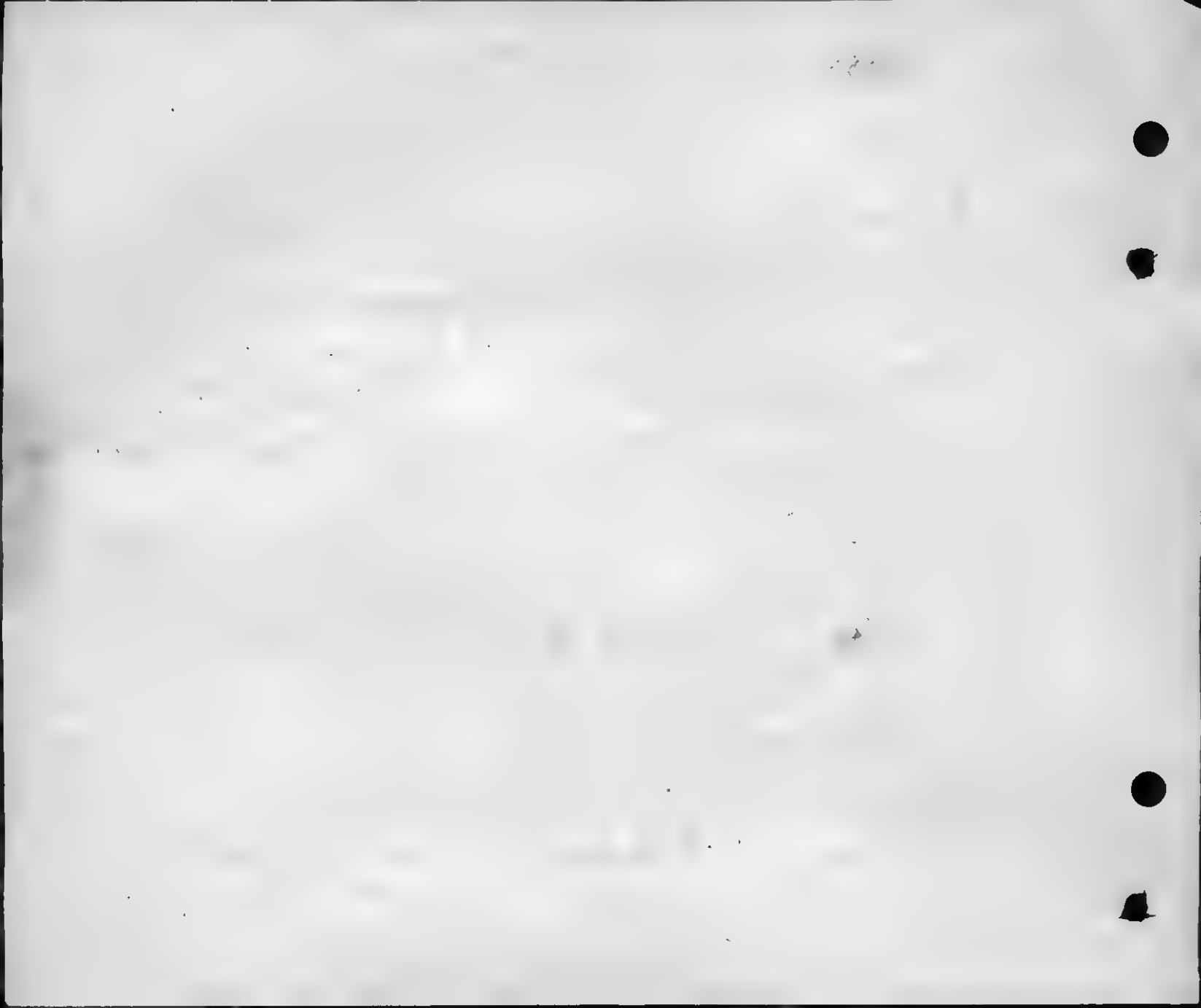
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13487

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**  
13467

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY in lb <u>6 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>98 College Creek Terrace</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> d. STREET ADDRESS <u>98 College Creek Terrace</u> <div style="text-align: right;">• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>CATHERINE LENORA JOHNSON TURNER</u> First Middle Last		<b>4. DATE OF DEATH</b> <u>Dec 17 19 61</u> Last Month Year	
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>C</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Feb. 22-1916</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Annapolis, Maryland</u>	
<b>13. FATHER'S NAME</b> <u>John A. Johnson</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>217-16-1910</u> <b>17. INFORMANT</b> <u>Elizabeth S. Johnson</u> Address <u>Annapolis, Md.</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>174 X</u> DUE TO <u>Carcinoma of the uterus</u> Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death 1 year</u>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State) <u>Annapolis</u>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Dec 17 1961</u> <b>to</b> <u>Dec 17 1961</u> <b>that (I) (we) last saw the deceased alive on</b> <u>Dec 17 1961</u> <b>and that death occurred at</b> <u>11:45 P.M.</u> <b>the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>R.L. Richardson</u> <b>22c. PHYSICIAN'S NAME</b> (Type) <u>R.L. Richardson</u>		<b>22b. DATE SIGNED</b> <u>Dec 12 1961</u> <b>22d. ADDRESS</b> <u>110 Clav St. Annapolis, Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>12-21-61</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>C.E. Hicks</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Brewer Hill</u> <b>23d. LOCATION</b> (City, town or county) (State) <u>Annapolis, Md.</u>	
<b>25a. REC'D BY REGISTRAR</b> <u>DEC 22 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>C. S. Evans</u>	



VR A15 (4)  
15M 9/60



FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13489

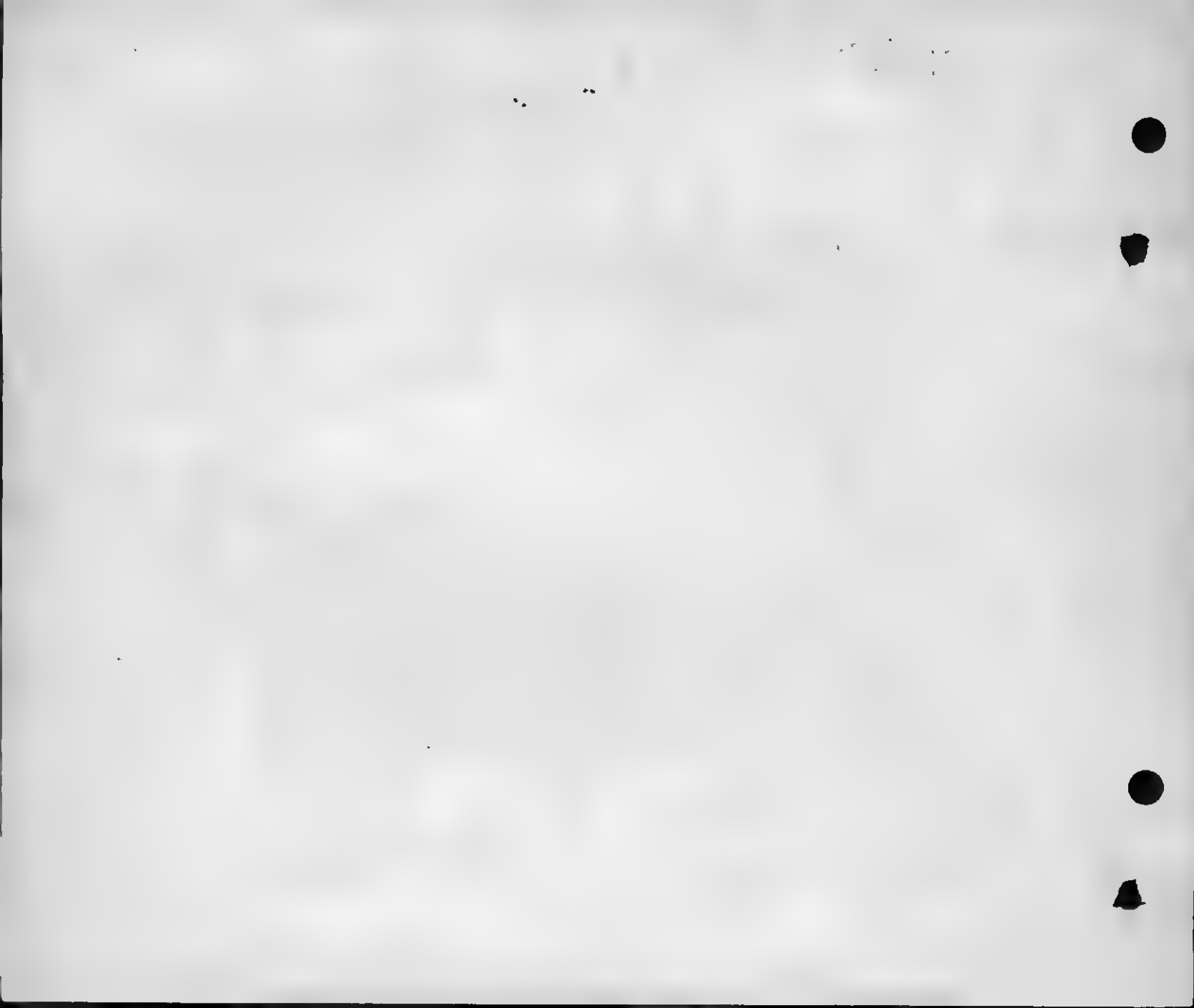
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14653

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u>		b. STATE <u>MARYLAND</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>UNKNOWN</u>		4. DATE OF DEATH <u>Feb 24 - 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>unknown</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>UNKNOWN - (Newborn)</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia - Face wrapped in plastic bag</u> DUE TO (b) <u>98 3X</u> DUE TO (c) <u>14</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Found in Woods - Face wrapped in plastic bag</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>Unknown</u> p.m. <u>Unknown</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Field</u>	20f. (City or town) <u>A.A.</u> (County) <u>md.</u> (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>R.F. Fisher</u>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>R.S. Fisher</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>1-9-62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Woodland Med. School</u>		22d. LOCATION (City, town, or country) <u>Baltimore, Md.</u> (State)	
23. FUNERAL DIRECTOR		24a. REC'D BY REGISTRAR <u>JAN 11 '62</u>	
		24b. REGISTRAR'S SIGNATURE <u>Wm. S. Thomas</u>	

VS. A15ME  
5M 9/60

9VVVVVVXVV



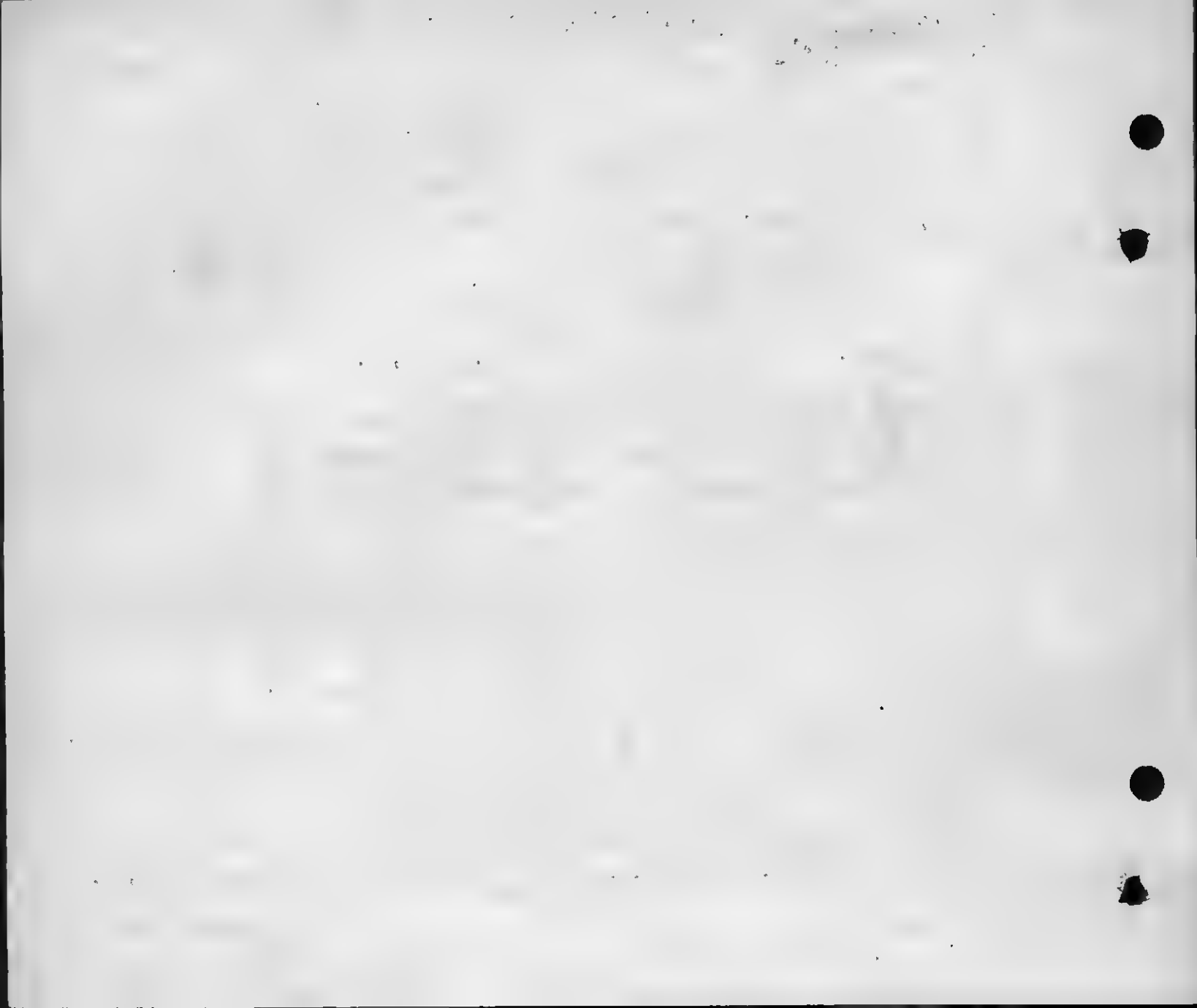
16  
FOR STATE  
HEALTH DEPT.

13490  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13469

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Severna Park</b> c. LENGTH OF STAY IN 1b <b>25 years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Old Annapolis Blvd.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Same</b> b. COUNTY <b>Same</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Same</b> d. STREET ADDRESS <b>Same</b>		<input checked="" type="checkbox"/> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John White</b>		4. DATE OF DEATH Month <b>22</b> Day <b>22</b> Year <b>1961</b>		5. SEX <b>M</b>	
6. COLOR OR RACE <b>C</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/9/79</b>	
9. AGE (In years last birthday) <b>82</b> yrs.		10. BIRTHPLACE (State or foreign country) <b>A.A. County, Md.</b>		11. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired labor.</b>		10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Arthur White</b>		14. MOTHER'S MAIDEN NAME <b>Mrs. Marjorie Howard (daughter)</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Marjorie Howard (daughter)</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Charred above recognition</b> 9/16.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Was trapped in his house which burned down.</b>		20c. TIME OF INJURY Month <b>12</b> Day <b>22</b> Year <b>1961</b> Hour <b>10:30</b> a.m. <b>A.M.</b> p.m.	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Severna Park</b> (County) <b>A.A.</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Gustave H. Faubert</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>12/22/61</b>	
EXAMINER'S NAME (Type) <b>Gustave H. Faubert, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-24-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Carpenter Hill</b>	
22d. LOCATION (city, town, or country) <b>Severna Park, Anne Arundel Co</b>		22e. ADDRESS (Street, city, town, or county) <b>Glen Burnie, Md.</b>		22f. REGISTRAR'S SIGNATURE <i>Charles E. Hicks</i>	
23. FUNERAL DIRECTOR <b>Charles E. Hicks, 11 Annapolis, Md</b>		24a. REC'D BY REGISTRAR <b>DEC 27 '61</b>		24b. REGISTRAR'S SIGNATURE <i>Charles E. Hicks</i>	

TO THE DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, or delay is necessary, by the physician, or if the physician is not available, by the medical examiner, or if the medical examiner is not available, by the health officer, or if the health officer is not available, by the coroner, or if the coroner is not available, by the medical examiner's office. This certificate should be executed in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO THE FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



13491

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

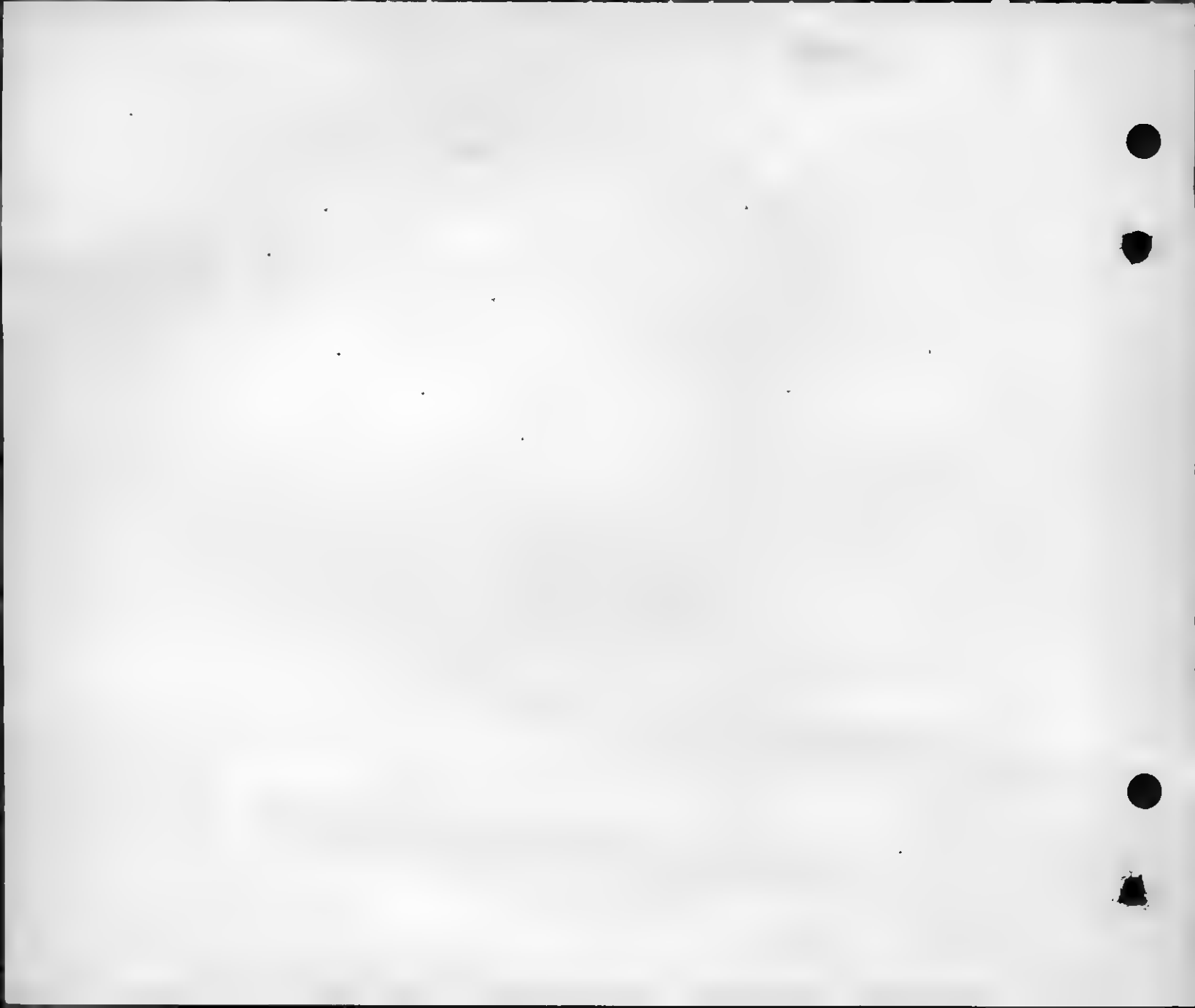
13470

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Odenton</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>15 Greenwood St.</b>				d. STREET ADDRESS <b>15 Greenwood St.</b>			
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>A</b> Last <b>WHITTLE</b>				4. DATE OF DEATH Dec. 27 19 61			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 25, 1887</b>	
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Merchant</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>General Store</b>		11. BIRTHPLACE (State or foreign country) <b>Odenton, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Charles A. Whittle</b>				14. MOTHER'S MAIDEN NAME <b>Annie M. Watts</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <b>217-32-9162</b>		17. INFORMANT Address <b>Mrs. Beverly Wood - Daughter - same as # 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Emboli</b>							<b>10 min.</b>
4221 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) <b>Arteriosclerotic Cardiovascular Dis.</b>							<b>20 yr.</b>
(c) <b>Arteriosclerosis, generalized</b>							<b>20 yr.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (the hospital) attended the deceased from <b>Dec 24, 1961</b> to <b>Dec 27, 1961</b> that (I) (we) last saw the deceased alive on <b>Dec 27, 1961</b> and that death occurred at <b>6 P.M.</b> from the causes and on the date stated above							
22a. SIGNATURE <b>Robert L. Damm</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12/24/61</b>	
22c. PHYSICIAN'S NAME (Print) <b>ROBERT L. DAMM</b>				22d. ADDRESS <b>106 GLENLEA DRIVE</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>DEC. 31, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BETHEL NICHOLS</b>		23d. LOCATION (City, town, or county) (State) <b>ODENTON, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping and Kirkley</b>				ADDRESS <b>Glen Burnie, Md</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 3 '62</b>	
				25b. REGISTRAR'S SIGNATURE <b>Robert L. Damm</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13492

## CERTIFICATE OF DEATH

13471

1. PLACE OF DEATH a. COUNTY <i>AA</i>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>AA</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Jacobs Mills</i>		c. LENGTH OF STAY IN 1b <i>X Jacobs Mills</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Four Smallwood Rd</i>		d. STREET ADDRESS <i>Four Smallwood Rd.</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>John Edward Williams</i>		4. DATE OF DEATH Month Day Year <i>12 / 27 1961</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-21-90</i>
9. AGE (In years last birthday) <i>71</i> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Printer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Am Label</i>	
11. BIRTHPLACE (County & State or foreign country) <i>Ind.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Lutke</i>		14. MOTHER'S MAIDEN NAME <i>Mary Fogler</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. (If yes give number or dates of service)	
17. INFORMANT <i>Family - Name</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Intestinal Obstruction</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Metastatic Carcinoma of stomach</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i> <i>7 mos.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <i>July 1961</i> to <i>Dec. 27, 1961</i> , that (I) <i>last</i> saw the deceased alive on <i>Dec. 20</i> 1961, and that death occurred at <i>2:45</i> PM, from the causes and on the date stated above.			
22a. SIGNATURE <i>C. Earl Hill</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>C. EARL HILL</i>		22d. ADDRESS <i>3708 Mountain Rd. Pasadena, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>12/30/61</i>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <i>Green Haven</i>		23d. LOCATION (City, town or county) (State) <i>Baltimore</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>W. E. G. Fogler</i>		25a. REC'D BY REGISTRAR DATE <i>DEC 29 '61</i>	
ADDRESS <i>130 E. Fogler Ave.</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Knecht</i>	

1943



John Edward Williams 12/27/41

Western Union  
Radio  
Cable

Metropolitan  
Police Department

Per 20 of  
the City of New York

EAST HILL  
New York

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13493

13472

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Dead on arrival to Anne Arundel General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Davidsonville</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Martin</b>		4. DATE OF DEATH <b>ZEHNER</b> <b>12 15 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 15, 1890</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tobacco</b>	
11. BIRTHPLACE (Country & State, or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Andrew Zehner</b>		14. MOTHER'S MAIDEN NAME <b>Anna Neubauer</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>218-36-1498</b>	
17. INFORMANT <b>Mrs. Mariea Zehner- Wife- Same as #2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a). <b>44</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <b>Hypertensive Cardiovascular Disease</b> <b>Cardiac Hypertrophy</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Not Known</b> <b>5 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 1961</b> to <b>Dec 1961</b> , that (I) <b>(we)</b> last saw the deceased alive on <b>Dec 12 1961</b> , and that death occurred at <b>5 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Francis I. Codd</b> M.D.		22b. DATE SIGNED <b>12-16-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Francis I. Codd, M.D.</b>		22d. ADDRESS <b>Governor Ritchie Highway Severna Park, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 19, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Our Lady of Sorrows</b>		23d. LOCATION (City, town or county) (State) <b>Owensville, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b> ADDRESS <b>Annapolis, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 19 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

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